Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Year 2012 Hartsock Ruthella 25 6:10 AM September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Golden Living Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 5, 1916 Months Days Hours Min. 96 Pennsylvania 166-32-1959 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at Director Bedford Bedford PA 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15522 367 Nave Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nellie Mae ပ Nellie permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Sardus Cessna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 547 Hillcrest Drive, Carlisle, PA 17015 Sherry A. Kuffa / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Centerville, PA Union Cemetery 09/28/2012 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service I 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Viscare Immediate Cause (Final Ph sician/ Coronar disease or condition resulting in death) Medical Due to (or as a consuluence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 22 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (MSEP 2°6°) 2012

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Sunil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD Registrar's Signature ank.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0033280

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct 6, 2012 8:55 AM M Wavne Hudson Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS-RMC Cumberland 6. Sex 8. Date of Birth Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Month, Day Year 1935 Director 1 🕱 M 2 🗆 F 214-34-1753 77 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified Cumberland MD Allegany 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 208 New Hampshire Avenue 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. by 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinance. Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Tri-State Oxygen owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Bolinger Wilbur Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 208 New Hampshire Ave. Wanetta Hudson wife Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ **X**remation 3 ☐ Removal from State 10/9/2012 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service L 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Il any, leading cause. Enter Underlying Cause (Disease or injury Examine Date for paid generalisings of: the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death FARURE 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital. 2 No မ 1 Tes 1 Inpatient 2 FR/Outpatient 3 DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? -1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 5 eted cause of death (Item 23a) (Type, Print) nes

Registrar

Physiciar Medica Examine	,	1. Decedent's Name (First, Middle	1 004)								
Medica			e, Last)			•		Date of Death Month		3. Time of Deat	
Examine	al	Norman 4a. Facility Name (if not institution	Howard		acksor			Sep 25		2100	
	er	Frostburg Villa	_	,		Frostb	or Location of Death		4c. County of I		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth			
Director		185-36-7525 Usual Residence of Decedent	1 X M 2 □ F	68 6	7 Yrs.	Widita Bays	TIOUIS WIII.	8. Date of Birth (Month, Day,) Sep 10,	1944	Birthplace (State or Fore	
giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	ō	10a. State 10b. County		10c. City,	Town or Loc	ation				10d. Inside City Lim	
28a-f otifiec	Director	OH Sta	ark		Can	ton				1 X Yes 2	
3a or		10e. Street and Number				10f. Zip Code		10	g. Citizen of Wha		
must must	Funeral	6633 Harvest		N.E. dent Ever in U.S.	12 1/	/as Decedent of h	44718	ocify Voc or No	US		
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ural",	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes. Vietna	m 1	☐ Yes 2 🔀 No	Specify:		Specify:	white	
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t of Health and Mental H	- 1	19a. Informant's Name/Relations					and Number or Rura				
ا ا ا ا	-	Keith Jackson 20a. Method of Disposition	<u>\$</u>	son			Cresap#			MD 21502	
nt of h		1 X Burial 2 ☐ Cremation		State cen	netery, crem	sition (Name of natory or other pla e Memoria	ce)	Date 2 10/1/2012	oc. Location - Cit!		
Department of Important: If any injury or once.	ŀ	4 Donation 5 Other (\$21. gnatur of Fune al Service L		Valle					Kina oi	Prussia PA	
any po		& Am	Dom .			Scarp	es of Facility elli Funeral Ho irginia Avenue	ome, PA	d MD 2150	2	
		23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that c	aused the death.	Do not ente		•			Approximate Interval Between	
sician/	ı,	Immediate Cause (Final disease or condition	M	ETA CDA	-17,	MELA	NOMA			Onset and Death	
Medical xaminer		resulting in death)	Due to (c	or as a conseque	nce of):						
	ē	Sequentially list conditions, if any, leading to immediate	b. — Duo to (or as a conseque	nce of:						
_nsit	Examiner	Cause (Disease or iinjury	Due to (t	or as a conseque	noc oij.						
		that initiated events resulting in death) Last	C. Due to (or as a consequer	nce of):						
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for use	ian,	23b. Was decedent pregnant in the past 12 months?	1 Live E	come of pregnanc Birth 2 Fetal c nant at time of dea	death 3 🗆	Ectopic pregnan Other (specify)	су		23d. Date o Month	f delivery Day Year	
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ned by	by P								e. Did tobacco use contribute to the cause of death?		
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ate ha	S S							perform	ed? deat Mo 1 □		
ertific sctor,	Be	25. Was case referred to medical examiner?	Hospital				lace of Death (Check	(only one)			
this cral dire	잍	1 Yes 2 PNo 27. Manner of Death	Hospital:	Inpatient 2 El	R/Outpatien 8b. Time of		4 Nursing Ho	me 5 Residen		Specify)	
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	gate	1 Natural 5 Pendir 2 Accident Investi	ng (Mont	h, Day, Year)	injury	28c. Injui wor M 1		28d. Describe how	nijury occurred		
ector: by the	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At hom	e, farm, stre					r Rural Route Number,	
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uners ed fille	Medical		Physician: To the be							s stated. the cause(s) and manner	
the F	— r	only one) 3 Certifying	Nurse Practioner:			eath occurred at the	ne time, date and place	e, and due to the c	ause(s) and manne	er as stated.	
		29b. Signature and title of certifier	<			29c. Licens			d. Date signed (M		
10		30. Name and address of person	Healm			1 26	101	3	DEL"/EMB	ER 26, 201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 33004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year. Eva L. Jackson 7.51 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Regional Medical Center Allegany Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours September 06, 1928 196-22-0899 84 Pennsylvania **Director** 1 M 2 X F Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified Maryland Allegany Frostburg 1 X Yes 2 No 10e. Street and Number 10036 Winners Lane NW 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 21532-U.S.A. ral", or items 2 Examiner mus permit. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: Black 3 Widowed 4 Divorced Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the N 0 Clerk Convenience store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Bert Bryant Florence Bibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annetta Alexander sister 4146 E 116 St Cleveland Ohio 44105-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory Date 20c. Location - City or Town, State i of ... 1 🗆 Burial 2 🔀 Cremation 3 🗀 Removal from State Department of Important: If any injury or \$eptember 26, 2012 Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Functal Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Ticholas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph_sician/ disease or condition resulting in death) CENT Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. cause. Enter Underlying
Cause (Disease or injury Due to for as a consequence on and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death 4 Pregnant
9 Unknown 9 Unknown Division of Vital Records, P.O. is certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has i completely filled in by the funeral director, page 22 completely filled in by the funeral director, page 22. autopsy performed 1 ☐ Yes 2 🗷 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year)

State

12502 Willowbrook Rd, cumberland,

21502

MD

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

Khanna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct 3, 2012 1:45 PM M **Johnston** Brenda Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany 210 Allendale Avenue Cumberland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday Birthplace (State or Foreign Country)

 M Funeral 8. Date of Birth Aug 19, 1946 Director 212-44-5261 Usual Residence of Decedent 1 □ M 2 🛛 F 66 28a-f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** MD LaVale Allegany 1 X Yes 2 □ No or 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? 23a 21502 USA 210 Allendale Avenue 'natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕇 No Specify. Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) own home 12 homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
210 Alloadolo Avenue I aVale MD 21502 19a. Informant's Name/Relationship (Type, Print) Woodrow Johnston husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Restlawn Memorial Gardens 10/6/2012 MD LaVale 4 Denation 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA ignatur of Fur eral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ LIVER Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying by Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Por in the past 12 months? Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FAIL YZE 1 Yes 2 No 3 Probably 4 Unknown Completed DIABOTES 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending Accident Suicide Investigation within 24 hours after deat

To the Funeral Director;
completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month. Day, Year) D0034812 2012

N&S State

Registrar

DHMH 17 Rev 06-2011

Dr. Cumberland, MD

who completed cause of death (Item 23a) (Type, Print)

909B
 32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2012 33006 State of Maryland / Department of Health and Mental Hygiene Andrew Kahla 1- For State Certificate of Death Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 24, 2012 1156 hrs **Medical Examiner** Andrew P. Kahla 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery 3226 Spartan Road # 54 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 24Hrs. 5. Social Security Number If Under 1 Year 6. Sex **Funeral** Min. Months Davs Hours Director 07/27/1982 Country) Maryland 215-04-5599 30 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits any 10a. State 10c. City, Town or Location 1 Yes 2 X No MD Montgomery Sandy Spring items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1030 Windrush Lane 20860 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. must be White, etc. Armed Forces 1 Never Married 2 Married 2 X No Yes White Yes 2 No specify: Specify: 3 Widowed 4 Divorced Give Year ≥ Dates 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical MD 21215-0036 2 Project Manager Communications 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Kahla Paula Kessler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other traumatic Paula Kahla / Mother 1030 Windrush Lane, Sandy Spring, MD 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crem. 09/26/12 Alexandria, Virginia 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Barber Funeral Home P. O. Box 5038, Laytonsville, 20882 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician en Onset and failure. List only one cause on each line. Medical Death a. Carbon Monoxide Poisoning Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. iner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical UNPENDED AMENDED signed by the attending physician be detached for use as the burial -Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the Year Month Day 3 Ectopic pregnancy 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>á</u> 1 Yes 2 No 3 Probably 4 Unknown Completed ificate has been sir, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 V No 1 TYes 2 No this certificate 26.Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA 2 No 1 🗸 Yes After thus 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject inhaled charcoal grill fumes Certification To the Hospital or security within 24 hours after death.

To the Funeral Director: A 1 Natural FOUND: 1 Yes 2 ✔ No Pending Sep 24, 2012 1156 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 3226 Spartan Road # 54, Olney, MD determined (Specify) Multi-Family Apt. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. September 25, 2012 30. Name and address of person who completed cause of death (Item 23a) O, Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State acks Registrar 11 21 Cart

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #5, per fh, g933 11-28-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24. Physician/ David Lightner John 2012 7:39 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15506 Peach Walker Drive Bowie Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. \$65 55822 166 976 5822 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Director 1 🛛 M 2 🗆 F 64 April 5, 1948 Pennsylvania Usual Residence of Deceden permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15506 Peach Walker Drive 20716 U. S. A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No USA
If Yes, Give
Year or Dates. 1968-70 Black, White, etc. 1 ☐ Never Married 2 🕅 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Construction Builder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Bernadine Grove Charles Metzler Lightner Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 East 33rd Street, Baltimore, Maryland 21218 Paige Shaeffer/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 🕅 Cremation 3 🗆 Removal from State 9/27/2012 Waldorf, Maryland Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final metastatic pancreatic cancer Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day 5 Other (specify) 4 Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sept 26, 2012 where mD D53070 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dan Lahere 1650 Orleans St Room 4m29 BaH, mD 21287 31. Date filed (Month, Day, Year) SEP 27 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended # 26, MLU Per Phy, 10/02/12 Allegany CO.

1 - State
Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ LECKEMBY 3:46 AM 2012 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ellerslie Allegany Hummingbird 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 215-42-4308 **Director** 82 -20-1930 PA Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director BEDFORD HYNDMAN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HYNDMAN 15545 "natural", or items 23a USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 № No Specify. Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemak 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emerick Anna Ash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Sis 10133 Hummingbird St Pa Box 185 Ellerslie MD 21529 DGH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HINUMAN FH'S & Crematury 9-29-2012 Johnstown PA 22. Name and Address of Facility HARVEY H. Zeigler F. H. Signature of Funeral Service Licensee 169 Clarence St HUNDMAN 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death Immediate Cause (Final Physician/ BREAST CANCE BS disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or). burial-transit Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 1 Yes 24 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an funeral director, page 2 autopsy perform Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Daughter's 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 X Other (Spe within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D0034812 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 909 B NALLIN MD SETON DR. CUMBERLAND MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT n 2 Registrar

12-07333 James B. Mattia Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolita, MD 21401								
Physician Magnetian 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or one heat failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List only one causes on each time Post List Charles Approximate failure. List charles Approximate	imore, Pages 1 a ment of He tant: If ite or other ti	12 X Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:	ory or other place) Careflet Ory and Veterans Cem					
Section Part Company	Balt permit. Depart Impor injury	18- J. Cm	12 Ridgely Ave. Anna	polis, MD 21401				
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AMENDED 23a, 27, 28a-f, per me, g932 10-16-12 sm Supply Suppl		cause. Enter Underlying Cause (Disease or injury that initiated						
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The state of the s	Box 6 e death cert the attendit ed for use a	past 12 months? 1 Yes 2 No 9 Unknown Unknown						
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25. Was case referred to medical examiner? 1	rds, require been si		24					
25. Was case referred to medical examiner? 1	ecol he law ute has	<u></u>	1	performed? death?				
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. September 29, 2012	al R entifica entifica ettor, pa	25. Was case referred to medical	26.Place of Death (Check only one					
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. September 29, 2012	F Vit	O 1 ✓ Yes 2 No 1 Inpatient 2 ER/O						
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29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. September 29, 2012	livisi lor Att after de Directe d in by t	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc. 28f. Lo or	cation (Street and Number or Rural Route Number, Town, State) 940 Fall Circle Wa	City			
296. Signature and title of certifier O.C.M.E. September 29, 2012 30. Name and address of person who completed cause of death (Item 23a)	hou hou	1/98 (entitler)	idence Gam	brills,MD.	- ,			
296. Signature and title of certifier O.C.M.E. September 29, 2012 30. Name and address of person who completed cause of death (Item 23a)	Fo the E within 24 Fo the F complete	(Check only one) 2 Medical Examiner: on the basis of examination and/or in and manner stated.						
30. Name and address of person who completed cause of death (Item 23a)		29b. Signature and little of certifier			-			
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\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	4 DEWE	Mary G. Ripple MD. Deputy Chief Medical Examiner	900 W. Baltimore Street, Baltimore,	MD 21223				
State State 31. Date filed (Month, Day, Year) 2012 32. Registrar's Signature Registrar 33. Date filed (Month, Day, Year) 2012			ball					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:50 A M David M. MacFarland 20 Medical വദ 4a. Facility Name (if not institution, give street and number) 4c. County of Death Caroline 4b. City, Town, or Location of Death **Examiner** Denton Caroline Nursing Home If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country)
Pennsylvania Days Months Hours Min. (Month, Day, Year) 85 **Director** 216-22-0530 1927 Usual Residence of Decedent sho 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland must be notified at Director 28a-f 1 Yes 2 No Ridgley Caroline MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21660 14482 Cherry Lane ral", or items 2 Examiner mus Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. lant; If item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator DuPont Manufacturing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Marrow John George MacFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Burrsville Rd. Harrington, DE. 19952 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr David MacFarland, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Oct. 6,2012 Greensboro, Md. Greensboro Cemetery | 22. Name and Address of Facility Fleegle & Helfenbein Funeral Hm. 21. Signature of Funeral Service Licenses 106 W. Sunset Ave, Greensboro, MD, 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Priysiciani Cerebrova Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physiciar page 2 should be detached for use as the buris To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No Yes 9 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tyes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 Tyes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natura 5 Pending 2 Accident
3 Suicide
4 Homicide M 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of

31. Date filed (Month,

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10a-f Per FH G933 11/16/2012 JH State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 09 Day 29 Physician/ Massey PM Lee 9:11 rna 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Telegraph old Roo Warwick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🗆 M 2 🕱 F Month Hours 222-14-4156 85 Director MARYLAND VOV. Usual Residence of Decedent 10b. County **Kent** permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any injury or other traumatic events. 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Smyrna 1 Yes 2 No 10e. Street and Number 10f. Zip 9977 10g. Citizen of What Country? 49 Larkspur Lane Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Kirby Metz Helen Orna Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Byrneberry Ct, Magnolia, De Cert Massey 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 10-4-12 Dover, Delaware 4 ☐ Donation 5 ☐ Other (Specify) akeside Cemetery 22. Name and Address of Facility
FORBERT FUNCTOR
6:3. Bradford 21. Signature of Funeral Service Licenses C HAROL mille action 2 Dover DE 19904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Dunknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🂢 No 24a. Was an autopsy performed Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1X Natural 5 Pending 2 Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year D0062190 MD 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHNAWAZ ICHAN MD
2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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			For State Registrar			•	tificate				-	Reg. No.	201	2 3	301
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Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State C	Place of Dispo	natory or o	ther plac		ι	Date			Town, State	
altin	permit, Page 1 Department of Important: If I any Injury or once.		4 ☐ Donation 5 ☐ Other (Kid	gely C	emete . Name an				/2012 oore Fu	Ridge neral			
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Box 6876	death certificate b ne attending physi ed for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	come of pregna	aldeath 3	Ectopic p		y			23d.	Date of de	elivery Day	Year
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Division of Vital Records, P.O.	al or Atte after de Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 28e. Place	of Injury - At hong, etc. (Specify	ome, farm, str	eet, factory	, office			28f. Location (City or Tov		m <i>ber or Ru</i>	ral Route Nu	mber,
_	To the Hospital or Attending Physician: To thin 24 hours after death. To thin 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Medical	(Check 2 L Medical	g Physician: To the b Examiner: On the bas g Nurse Practitioner	is of examination	n and/or inves	tigation, in r	my opinio	on, death or	ccurred at	the time, date a	and place, and	due to the	cause(s) and	manner state
	To the vithin To the comp	2	29b. Signature and title of certific	Nurse Practitioner	M/D	ny knowledge,		. License	number		ice, and due to	29d. Date sig	ned (Mont	h, Day, Year)	
)		30. Name and address of person	who completed caus	e of death (Item	23a) (Type. F	Print)	150	750			9-2	9-12	-	
			Pohort Cancha	- M D	508 Id	lewild		E	Easto	n, M	D 2160	1			
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DHMH 17 Rev 06-2011 BIZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James Lee Myers Month September 25, 2012 08:24 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Care Center Allegany Frostburg Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Months Hours Month, Day, Year March 26, 1937 75 **Director** 214-36-6338 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Maryland Allegany Frostburg 1 ¥ Yes 2 ☐ No 10e. Street and Number 100 Braddock Street 9 10f. Zip Code 10g. Citizen of What Country? items 23a Unit 104 U.S.A. 21532 death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If flem 27 is marked other training or o 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 2 X No Yes Yes Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Maintenance County Roads Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James A. Myers Evelvn Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay Myers wife 100 Braddock, Unit 104 Frostburg Maryland 21532-20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) September 26, 2012 Cumberland Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ZHEIMI disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ng physician and as the burial-transit that initiated events certificate be exect resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Unknown g 🗌 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by sate has been signed page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? the Hospital or Attending Physician: The hin 24 hours after death.

the Funeral Director: After this certificate Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Hospital 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 5 D26907

Registrar

DHMH 17 Rev 7/2009

State

Bishop Walsh Rd, Cumberland,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

32. Registrar's Signature

Sidhu

Harjit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Delores Jane Miller Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Cumberland Allegany Western MD Regional Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Days Hours Min (Month, Day, Year) **Director** 1 M 2 XF 185-26-2171 77 Yrs 01/08/1935 Pennsylvania Usual Residence of Decedent nand Mental Hygiene. I is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director PA Bedford Bedford 1 Yes 2X No 0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3654 Evitts Creek Road 15522 USA permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black. White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Williams Sherman Harold Gertrude Angela Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3654 Evitts Creek Road, Bedford, PA 15522 Beverly Roberts/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Union Cemetery 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/06/2012 Centerville, PA 4 ☐ Donation 5 ☐ Other (Specify) Signiture of Funeral/Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part N Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of **Examiner** frank, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) ____ Month Pregnant at time of death been signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performe this certificate 1 Yes 2 No the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the vest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 101 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) w OCTODER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Seton Drive, Cumberland, MD 21502 Vik Poonai, M.D.,

State

Registrar

31. Date filed (Month, Day, Year)

OCT 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09^{Month} Day 2012 Year Christopher George Ortiz 24 6:27A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Funeral 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours 062-52-3793 Director 1 X M 2 □ F 57 06/07/1955 New York ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery 1 Yes 2 ☐ No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20908 800 Downs Drive USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status ò 1 Never Married 2 Married ☐ Yes 2 🕅 No Maryland 21215-0036 1 X Yes 2 □ No 3 ☐ Widowed 4 🎦 Divorced If Yes, Give Specify: White Specify: Puerto Rican Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me 03^{College (1-4 or 5+)} Elementary/Secondary (0-12) Pharmaceutical Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Fernandez Ortiz Muriel Alva Seidl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adam Ortiz/ Nephew 4702 Gallatin Street Edmonston, MD 20781 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory Glen Burnie,MD 4 ☐ Donation 5 ☐ Other (Specify) 09/30/2012 21. Signature of Funeral Service Lig 22. Name and Address of Facility 22. Name and Address of Facility
Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Asystole Medical Due to (or as a consequence of): Examiner Cardiorespiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cardiogenic Shock that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 🖺 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D65305 09/24/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Nabila Khan M.D

SEP 27

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

Registrar's Signature

1500 Forest Glen Road Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCL. 2012 William Jackson Patrick 7:45 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Caroline Envoy of Denton Denton Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funera Days Hours (Month, Day, Year) 220-34-9449 Director 1 X M 2 □ F Feb. 17,1939 Virginia 73 Usual Residence of Decede r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Caroline Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25595 Auction Rd. 21632 United States within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married ð 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Owner/Operator Truck Driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever pe Lillian Clear Patrick t. Page 1 and 2 should be treent of Health and Men trant. If item 27 is marke Henry J. Patrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5531 American Corner Rd., Federalsburg, MD 21632 Brenda Hudson/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 🗀 Donation 5 🗆 Other (Specify) Hill Crest Cemetery 10/9/2012 Federalsburg, MD Signature of Funeral Service License 22. Name and Address of Facility Framptom Funeral Home 216 N. Main St., Federalsburg, MD 21632 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner oron Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Ducito for as a consequence of: sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death ed by the at detached for 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate Yes 2 DAN 1 ☐ Yes 2 ☐ No director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Mursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 124 hours after death. e Funeral Director: Aft letely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 7534 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wafik Zaki, MD 836 S 5th Ave. MD 21629 Denton 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oct Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 **Physician** October 3, 9:20 РМ Richard Carlton Pratt /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Calvert 1065 Shirley Way Prince Frederick 8. Date of Birth (Month, Day, May 23, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
New York Sex 1 M 2 □ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1934 Months Days Hours 051-28-6194 78 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Euprine rough be notified at once. 1 □Yes 2 No Director Prince Frederick Maryland Calvert 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20678 1065 Shirley Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No 1958
If Yes, Give Year or Dates: 0 1964 Black, White, etc. 1 Never Married 2 Married 1 □Yes 2X No þ Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) High School 5+ Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Grace Harvey Raymond Chamberlain Pratt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1065 Shirley Way Prince Frederick, MD 20678 Kirsten Trenton/daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Eastern Shore Veterans Cem 10/10/2012 Hurlock, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Signature of Funeral Service Denton, Maryland 21629 12 South 2nd Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** angestive flight disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner METERI CORONOLEY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month in the past 12 months? Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 □ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 24 No this certificate 2 No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To after death. 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a

Medical

The law requires that the death certificate be executed

Attending Physician:

Hospital or

To the within 2

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar Raymon Noble

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated.

10/4/2012

29d. Date signed (Month, Day, Year)

Prince Frederick, Maryland 20678

31. Date filed (Month, Day,

29s. Signature and title of certifier

29a. Certifier

ORIGINAL

TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DHMH 17 Rev 1/2001

BAY

1. Decedent's Name (First, Middle, Last)

Dawn Louise Rehbein

Physician

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

Day

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

ur. 10mTHS

Year

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

10-2-2012

White

1 Yes 2 No

To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records. ours after death.

leral Director: A
filled in by the fu within 24 hours a

þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an performe 1 ☐ Yes 2 🔀 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 Residence 6 \subseteq Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar David Smith,

31. Date filed (Month, Day, Year)

ULI 0 4 2012

32. Registrar's Signature

8221 Teal Drive, Suite 302

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

DHMH 17 Rev 1/2001

D39887

Easton, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rice 100 Medical Albert 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth (Month, Day, Year) Feb 10, 1926 213-22-2696 Usual Residence of Decedent Director 1 🔀 M 2 🗆 F 86 show 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f MD Allegany Cumberland 1 Yes 2 No 10e. Street and Number ö 10f. Zip Code must be n 10g. Citizen of What Country? Funeral 216 Maple Street 21502 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates. WWII/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural" 3 Widowed 4 Divorced Completed WWII/ Korea white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) crane operator Railroad other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည Rose Maffley Albert Rice Sr. Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Katherine Rice MD 21502 wife 216 Maple Street Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 9/22/2012 Donation 5 Other (Specify) Sunset Memorial Park Cumberland MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA of Funy ral Serv Licensee gnatur 108 Virginia Avenue: Cumberland, MD 21502 23a. Parky Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause of each line Interval Between Onset and/Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) neumone Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 SB attending p IF FEMALE: JSe 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 1 Yes 2 L 9 Unknown Unknown signed by to be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ၉ 1 Yes 2 1 No Other: 1.4 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending neral Director: A rilled in by the f Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral Medical 29a. Certifier 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and ti 20033280 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kent Ave. Ste. 101 Cumberland

Registrar DHMH 17 Rev 06-2011

State

1.625

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9/26/2012 Physician/ KEITH RICHARD SCHREIBER 7:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1688 NORTH HARBOR COURT ANNE ARUNDEL ANNAPOLIS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) 213-30-6343 1 X M 2 □ F **Director** 80 8/14/1932 MARYLAND Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🗓 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 1688 NORTH HARBOR COURT 21401 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2X Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Year or Dates. 1950 WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than " Elementary/Secondary (0-12) College (1-4 or 5+) ELECTRICAL ENGINEER ENGINEERING Department of Health and Mental Hygien Important: If item 27 is marked other 1 any injury or other traumatic event, th once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ RUTH BROOKS HENRY A. SCHREIBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1688 NORTH HARBOR COURT, ANNAPOLIS, MD 21401 MARIETTA SCHREIBER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESA FEARE CREMATION 9/27/2012 1 Burial 2X Cremation 3 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility LASTING TRIBUTES BY FELLOWS Signature of Tureral Service Lice Devil. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Amoto set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ohic Years Medical ue to or as a contequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) g physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death Yes g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 Probably 4 Unknown 1 Yes Certificate: To Be Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No 1 ☐ Yes 2 € 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 Yes 2 No I Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 29b. Signat 017965

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Marylan State Registrar		artment of Hea <i>tificate of Dea</i>			ne No. 2 (112	33021		
	DI	.,	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 2:10 A							
***	Physicia Medic		George Clayton Stauffer					September 26, 2012 2				
	Examin	er	4a. Facility Name (if not institution, give street and number) 9532 Stauffer Road	4b. City, Town, or Loca	rsville		4c. County		lerick			
1	Funeral		Social Security Number 6. Sex 7. Age (In yrs. I.	last birthday)	If Under 1 Year If U		8. Date of Birth (Month, Day, Ye	nor!		ace (State or Foreign		
	Director		219−20−1162 Usual Residence of Decedent	Yrs.	I World S Days Fic		Nov.1, 1		Maryl			
	and show	ř		ty, Town or Loc	pation				- i	d. Inside City Limits		
	Maryl 28a-f otifiec	.≒	Maryland Frederick		Walke	ersville		_		1 ☐ Yes 2 X No		
	with the s 23a or ust be n	Funeral D	10e. Street and Number 9532 Stauffer Road		10f. Zip Code 2179	93	100	g. Citizen of V Unit	Vhat Countri Ced St			
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates	31	Vas Decedent of Hispan f Yes, specify Cuban, Mi ☐ Yes 2 XNo Sp	lexican, Puerto R	ify Yes or No- ican, etc.)		e - America k, White, et	c.		
9-0	hours natura Jical E	lete	15. Decedent's Education	16a. Deced	lent's Usual Occupation	1	16	ib. Kind of Bu	Whi siness/Indu			
121	vithin 72 iene. r than " the Mec	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO	kind of work done during O NOT use retired) Realtor	g F	Real Es	state				
land 2	be filed w ental Hyg ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Frank N. Stauffer		18.	Mother's Name Ethel	(First, Middle, Mai Mae Zimm	den Sumame l erman	:)			
Maryland 21215-0036	I 2 should lith and M 27 is mar r traumat		19a. Informant's Name/Relationship (Type, Print) G. Douglas Stauffer / Son	19b. Mailin	ng Address (Street and N	Number or Rural own Pike	Route Number, Ci	ty or Town, S	tate, Zio Co 1D 21	702		
Baltimore,	age 1 and ent of Hee nt: If Item y or othe		1 X Burial 2 Cremation 3 Removal from State	cemetery, crem	sition (Name of natory or other place)			c. Location -	-	n, State		
Baltir	permit. P Departme Importar any injur		21. Signature of Funeral Service Licenses		et Cemetery Name and Address of 1621 Opossi	Facility	Stauffer	Fune	ral Ho	ome		
N			23a Part 1. Enter the pisease or complications that can led the deat stack, or heart failure. List only one cause only at line.	h. Do not ente						Approximate		
in .	Ptrysician/		Immediate Cause (Final disease or condition	n n		Interval Between Onset and Death						
	Medical Examiner		resulting in death) Due to (or as a conjugation)	uence of):	1 -1	16	faile ada	6.				
		ner	Sequentially list conditions, if any, leading to immediate b. Due o (or as a consequence of the conditions).	uence of):	u cara	with	augu	ace	601			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events C	·a								
	zate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequ	uence of):								
760	icate b physics the t	ledical	d									
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	ysician/M		ysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnat 1 □ Live Birth 2 □ Feta 4 □ Pregnant at time of 6	al death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver	y Day Year
P.0	that th ned by e detac	by Pr	Part II. Other significant conditions contributing to death but not res		, 0	n Part I.	23e. Did tobac	co use contr	ibute to the	cause of death?		
ds,	quires en sig ould b	ted t	Vacemaker, hyper	lens	con		1 🗆 Yes	P No	3 Proba	ably 4 🗌 Unknown		
ecor	3 0001	Completed					24a. Was an autopsy performe	d?/ 0	rior to com leath?	sy findings available upletion of cause of		
al B	ian: Th		25. Was case referred to medical examiner?		26. Place o	of Death (Check	-	No 1	☐ Yes 2	! □ No		
Ĭ.	Physic this ce al dire	유	1 Yes 2 No 1 Inpatient 2			☐ Nursing Hon		e 6 🗆 Othe				
0	ding F th. After	cate:	27. Manner of D ath 1	28b. Time of injury	28c. Injury at work? M 1 🔲 Yes	2 🗆 No	8d. Describe how	injury occurre	ed			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Certificate:	Investigation 3 ⊆ Suicide 6 ⊆ Could not be determined 4 ☐ Homicide determined 28e. Place of Injury - At he building, etc. (Specify)	ome, farm, stre			8f. Location (Stree City or Town, S		er or Rural F	Route Number,		
_	e Hospita 124 hours e Funera letely fille	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my known only one.	n and/or invest	igation, in my opinion, de	eath occurred at t	he time, date and p	place, and due	to the caus	se(s) and manner stated.		
	To th withir To th comp	2	29b. Signature and little of certifier		29c. License nun			. Date signed				
			Whi figureth	MD	135	183		dene	her de	6,2012		
	30		30. Name and address of person who completed cause of cleath (Item	n 23a) (Type, P	rint)	Th C	Fra	lor,	1	p2)		
	Stat	e	3. Date filed (Month, Day, Year) 32. Rygistrar's Signa	ture	1 100	/	110 ECI		1			
	Registra	ar	DEP & 1 2012 Densus	B. 1	acked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 33022 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24, Physician/ Ursula 10:00 PM Louise Schneider 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Care & Rehab Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 138-12-7953 Director 1 - M 2 XXF 90 Yrs. Jan. 1, 1922 Germany Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Maryland Frederick Brunswick 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21716 United States 1402 Musgrove Alley 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Black, White, etc. Yes 2 X No 0 þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 er than "natural", c , the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Photography Photographer traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Egmont Alex Merseburger Ida Carolina Dettman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail L. Pearrell / Daughter 1220 Rosemont Drive, Knoxville, MD 21758 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. Date 26, 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) Frederick, Maryland Resthaven Crematory 2012 21. Signature of ineral Se v e Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick. 23a. Part 1. Enter the diseas shock, or heart failure complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Preset and Death Immediate Cause (Final CLODYSPLASTIC SYNIDNOME Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?

1 Yes 2 No Day Year Month 1 ☐ Yes 2 ₺ 9 ☐ Unknown the P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Division of Vital Records, 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 Yes 2 No Yes 2 No the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 I 4 X Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director, After this funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide the 1 Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi

State Registrar

DHMH 17 Rev 06-2011

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(Check

only one) 29b. Signature and ti

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

A DOLANUM

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 506 LL 23

PREDERICE, MD

Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Kenneth Ray Stewart, Sr. 8:33 PM 2012 Medical in 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico 5,00 Hospice at th If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) 220-66-4416 (Month, Day, Year) Director 1 🛛 M 2 🗆 F 57 July 21, 1955 Maryland Usual Residence of Deced item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD East New Market 1 X Yes 2 ☐ No Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Sugar Drive 21631 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 10 Carpenter Home Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jackson Andrew Stewart Erma Blades Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth R. Stewart, Jr. /son 20 Sugar Dr., East New Market, MD 21631 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MidShoreCremationCtr. 10/5/2012 Cambridge, MD Signature of Funeral Struige Licensee 22. Name and Address of Facility Framptom Funeral Home 216 N. Main St., Federalsburg, MD 21632 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ COOMA -IUBR disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown en alflalo pully 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes B B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital: HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie DOOS8410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) w State aistrar's Signature Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🕦 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milton Sarver 0627 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland 8. Date of Birth (Month, Day, Year, 01/28/1937 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours **Director** 216-30-1779 75 1 X M 2 D F Pennsylvania Usual Residence of Dece show or 28a-f shov notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Cumberland Allegany 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rms 23a or r must be r 9 Funeral 745 Dale Avenue 21502 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian. the Medical Examiner Armed Forces?
1

Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. ō ģ 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Brakeman Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Alma Pauline Sarver Clarence Shaffer ပ 19a. Informant's Name/Relationship *(Type, Print)* Judith Sarver / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 745 Dale Avenue, Cumberland, MD 21502 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Restlawn Mem. Gardens 10/08/2012 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. \$ign sture of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-trar and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be hin 24-horus after death.

The Funeral Director: After this certificate has been signed by the attending physicia pipelety filled in by the funeral director, page 2 should be detached for use as the bumpletely filled in by the funeral director, page 2 should be detached for use as the bumpletely filled in an experiment. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death 2 🗌 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No ္ဝ 1 🗌 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1- Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1+💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Optiving Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number DOU 33280 3+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sunil K. Gupta, M.D., 625 Kent Ave

Registrar DHMH 17 Rev 06-2011 oct of the filed (Month, Day, Year) OCT 0 9 2012

32. Registrar's Signature

625 Kent Avenue, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Kirkpatrick Todd, Sr. 2012 A M 9:04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Talbot 700 Port St. Apt. 322 Easton Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Days 213-22-9562 Director 1 XM 2 - F Feb. 23,1917 95 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumetic event, the Wedgall Examiner must be nortified as ORGE. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🎇 No Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 United States 700 Port St. Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Boat Sales 12 Yacht Broker æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Flora K. Todd Charles S. Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9960 Eagle Dr., Easton, MD 21601 John K. Todd, Jr./ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State MidShoreCremationCtr. 10/4/2012 Cambridge, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mid Shore Cremation Center Cambridge, MD 21613 Box 1464, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause Officease or injury Due to for as a consequence of: after deeth.

Director: After this certificate has been signed by the attending physician and in by the funerel director, pege 2 should be detached for use as the burlal-tran: that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 Yes 2 No Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Hospital or Attending Physicien: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours aft

To the Funeral Dir

completely filled in

within 2 To the F

Registrar

Medical

only one)

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ChnwordAr

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H4758

Easter MD 21601

City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary Elizabeth Twigg September 20, 2012 8:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Cumberland 4c. County of Death
Allegany 10 N. Liberty Street, Apt 612 . Social Security Number 8. Date of Birth (Month, Day, Year) 07/31/1924 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign **Director** 236-20-9533 88 1 □ M 2 🗓 F Maryland or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If ifiem 27: is marked other than "natural", or items 23a or 28a-f sho any injury or rother traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits s 23a or 28a-f shust be notified a Allegany MD Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 10 N. Liberty Street, Apt 612 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give White 3 X Widowed 4 Divorced Specify Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Nellie I. 2 William Ρ. Zembower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Smith / Daughter 12413 Snyder Drive, NW, LaVale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Cumberland Crematory 09/22/2012 4 Donation 5 Other (Specify) Cumberland, MD Signature of Funeral Services 22. Name and Address of Facility Adams Family Funeral Tome, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Udemocalemour of disease or condition resulting in death) ewy eary Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to miniculate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to for as a sur soduence of nding physician and use as the burial-tran Due to (or as a consequence of): that the death certificate be P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant ed by the attence detached for us 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas perform 1 ☐ Yes 2 💯 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2VDNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, Homa Steeley D46346 September 21, 2012

DHMH 17 Rev 06-2011

State Registrar Cumberland, MD

625 Kent Avenue,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Huma Shakil, M.D.,

31. Date filed (Month, Day, Year) **SEP 21** 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryla State 9/27/2012 AACO HEALIH DEPT. OMH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23, ^{Year} 2012 2:00 Dorothy Ann Vea Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) Director 220-60-7913 1 M 2 XF 59 6/17/1953 Maryland show 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Maryland Annapolis 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 107 Hickory Lane 21403 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 01 Black, White, etc. Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Heafth and Mentral Hygiene. Important If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinany injury or other traumatic event, in the Medical Examination of the contract of 2 **X** No Yes 3altimore, Maryland 21215-0036 White 1 Yes 2 X No Specify If Yes, Give 3 🗌 Widowed 4 🙀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Child Care Provider Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lawrence Thomason Mary Belle Rupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Shane Navy - Son</u> <u> 2706 Hamilton Avenue, Baltimore, MD 21214</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory | 9/26/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 147 Duke of Gloucester St, Annapolis, MD 21401 shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of). physician Physician/Medical Box 68760 the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Pregnant at time of death 5 Other (specify) Month Day Year Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion cause of death? ate has t After this certificate I 1 Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ဂ္ 1 Nnpatient ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred atural 5 Pending after death.

Director: Af
d in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a
To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number

State Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Albert James Via September 25, 2012 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 74 Centennial Street Allegany Frostburg Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 1 M 2 - F Months Days Hours **Director** 214-07-3860 95 September 28, 1916 Maryland 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Allegany Maryland Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 174 Centennial Street Funeral U.S.A. 21532 items 12. Was Decedent Ever in U.S. Armed Forces?

1 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner Race - American Indian Black, White, etc. P by 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after nan "natural", Medical Exan 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed, filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Motel & Restaurant Owner/Operator traumatic event, Be Department of Health and Mental Hy Important: If item 27 is marked oth, any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francesco Via Saveria Sicoli 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Linda Rando daughter 174 Centennial Street Maryland Frostburg Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park September 29, 2012 Frostburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final myreous Onset and Death Physician/ disease or condition resulting in death) nesley Medical Due to (or as a c sequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Just to for as a point of ence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical P.O. Box 68760 the attending plant IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 9 Unknown 9 Unknown as been signed by the 2 should be detach€ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s performed? 2 🗌 No 1 Yes 1 Yes 2 -25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 - No 1 Tes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work Accident 1 ☐ Yes 2 ☐ No neral Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

Registrar

3+

922 National Hwy, LaVale,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Anthony Bollino

2 6 2012

31. Date filed (Month,

SEP

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	Physicia Medic		1. Decedent's Name (First, Middle	Lilian Brov	vn Watkins			2. Date of Death Septembe	2. Date of Death 3. Time of Death September 23 2012 1529 PM					
	Examin	er	4a. Facility Name (if not institution Union Hospital	,		4b. City, Town, or Elktor	r Location of Death		4c. County of Death	1				
	Funeral Director		5. Social Security Number 222–22–6230	6. Sex 7. Age	e (In yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y NOV 13,	9. Birti	nplace (State or Foreign entry) aryland				
	nd h ow at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits				
	Maryla 28a-f s otified	Director	Maryland Cec	i 1	Elkton					1 ☐ Yes 2 🏋 No				
	th the	al D	10e. Street and Number	D 1		10f. Zip Code		10	og. Citizen of What Co	·				
	ath wi	Funeral	5821 Telegraph	12. Was Decedent 8	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	United St					
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Mar 3 🖫 Widowed 4 ☐ Divorced	If You Give A	No	If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	Ričan, etc.)	Black, White Specify: Whi	, etc.				
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re,	1 and of Hea item	Ш	20a. Method of Disposition		20b. Place of Disp			Date 2	20c. Location - City or	Town, State				
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Ball	permit. Page 1 a Department of I Important: If ite any injury or ot once.	l J	21. Signature of Funeral Service	Licensee	2				for Funera Elkton, M					
10	Medical Examiner	ed by Physician/Medical Examiner	Physician/Medical	Physician/Medical	Physician/Medical	Physician/Medical	23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Scale helly list accellent of any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a c.	Đ.	CA/dio	myops.	LHA	NEDICAL EXAMINER	Approximate Interval Between Onset and Death
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	ne Hospite n 24 hours ne Funera pleted fille	Medical	(Check 2 Medical I	g Physician: To the best of Examiner: On the basis of e	xamination and/or inve	stigation, in my opinio	on, death occurred a	nd due to the cause at the time, date and	e(s) and manner as sta place, and due to the c	ause(s) and manner stated.				
	Vithi To #	-	29b. Signature and title of certifie			29c. License		ı	d. Date signed (Month					
			30. Name and address of person	who completed cause of	eath (Itam 23a) /Tura	Print) (potember	29 2011				
100	Sta	ia.	30. Name and address of person 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	· DO NNELL	eath (Item 23a) (Type ar's Signature	print), to 32	1exple	Plata	مرليافرك ا	29 2011 K De 1970				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Physician/ Fredda C. Winnefeld September 7:30 2012 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ginger Cove Health Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, . Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign 726-07-2969 Director 1 M 2XXF 82 1929 October 20, Alabana or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Completed by Funeral 7205 River Crescent Drive with 21401 U.S.A. "natural", or items Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White If Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) event, the School Teacher Education ulth and Mental Hygien 27 is marked other the r traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fred Coupland Mamie Meade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Winnefeld, Sr./spouse Health a 7205 River Crescent Drive Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 9/28/2012 Baltimore, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee Kyelin 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ouet and Death Immediate Cause (Final disease or condition Ph_sician/ ernen Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of Cause (Disease or injury that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year Pregnant at time of death detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗠 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatuy 911. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 neno

DHMH 17 Rev 06-2011

State

Registrar

Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Evangelie A. Wilbourn 2012 September 11:35 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 10 , Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Egypt 578-58-4505 1 🗆 M 2 🔀 F Months Year) 82 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Anne Arundel Annapolis Maryland Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21403 7101 Bay Front Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White 3℃Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important. If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Realtor Real Estate 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Photini Criviadis Vasili Arfara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22311 Carolyn Miller/niece 5816 Colefax Avenue Alexandria, Virginia 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 9/27/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ clerade disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immedicause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Live Birth 2 Fetal death detached for Pregnant at time of death the Unknown 9 Unknow as been signed by 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed? certificate has page 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 🖊 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pendina death. after death Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral L Medical 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one A title of certif 29b. Signature a 29d. Date signed (Month, Day, Year) 58510 30. Name and addre ho completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 25 2012 Month Physician/ 11:00 AM September Wakefield Carlson Elizabeth Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick <u>Frederick Memorial Hospital</u> If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth . Age (In yrs. last birthday) **Funeral** Hours Days (Month, Day, Year) 577-34-4691 Director 1 M 2 X F 88 5, 1924 Sep. Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Evaminer must be notified at 10d. Inside City Limits parmit. Paga 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Items 23a or 28a-1 show Important: If Items 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Madical Evantinar Injust be nytified at any injury or other traumatic event, the Madical Evantinar Injust be nytified at any injury or other traumatic event. 10a, State 10c. City, Town or Location Director 1 Yes 2 No Frederick Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7351 Willow Rd. #10 21702 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 🗌 Yes 2 🖾 No If Yes, Give Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosalie Ericsson Ernest Robert Carlson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7351 Willow Rd. #10, Frederick, MD 21702 Harold Wakefield/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 09/26/2012 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory . Sign tune of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pars disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physician and for use as the burlai-transit Hospital or Attending Physician: The law requires that the death cartificeta be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death certificate has been signed by tha i iractor, page 2 should ba detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🔼 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No ရှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Just

31. Date filed (Month, Day, Year)

SEP 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Day Physician/ 1:00 PM Willison Lillian Regina 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Lions Center Allegany Cumberland Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** Mar 30, 1917 Hours 220-10-8809 Usual Residence of Deceden Director 1 🗆 M 2 💢 F 95 10a. State 10c. City, Town or Location 10d. Inside City Limits at the Maryland Director must be notified MD Allegany Cumberland 28a-f 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code or 10g. Citizen of What Country? 23a Funeral death with 901 Seton Drive 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iterr edical Examiner r 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify. Completed Specify. 3 XWidowed 4 Divorced white I Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>homemaker</u> own home of Health and Mental Hyginteen 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theresa Ash **Emory Runion** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norney Willison Cumberland MD 21502 912 Piedmont Avenue son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Department or Important: If any injury or once. # b 10/1/2012 Hillcrest Memorial Park Cumberland MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA LFuneral Privice Licens Signatu 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between et and Death Immediate Cause (Final -Ph_sician/ Corcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 25. Was case referred to medical filled in by the funeral director. 26. Place of Death (Check only one) Certificate: To Be examiner? Other 2 No ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Yorse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of sorti 10 29d. Date signed (Month, Day, Year) 28, 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD 21503 625 Kent MO State OCT 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{A}^{M} Barbara Roetzel Williams 8:47 9 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester Cambridge 110 N. Regulator Drive 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Director 296-28-1105 1 M 2 X F 6-27-1932 PA 80 items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location 10b. County other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Cambridge Dorchester MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21613 USA 110 N. Regulator Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married should be filed within 72 hours after ō þ Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Education 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Ellen Raffensberger Bernard J. Roetzel and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shc.
Department of Health and
Important: If item ?" :
any injure: Regulator Drive Cambridge, MD 21613 110 Edgar Williams/husband Ν. Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) ☐ Burial 2 🔀 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Mid Shore 10-1-2012 Cambridge, MD 22. Name and Address of Facility Signature of Funeral Service Licensee 308 High Street Newcomb&Collins FH Cambridge. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumon disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a con equence of) Cause (Disease or injury and the burial-trai that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 Pregnant the Unknown ed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 Reprobably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has director, page 2 performed' 1 Yes 2 No 1 Yes 2 No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director: Aft eletely filled in by the fu Investigation Accident 6 Could not be Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is an activity. Medical 29a. Certifier within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of 30. Name and addr completed cause of death (Item 23a), (Type, Print) Campi de Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 29 4101 Donald Paul Yoder Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 6. Sex g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Hours Min (Month, Day, Year) Jan 4, 1935 Director 215-34-4415 MD 1 X M 2 D F 77 Yrs. show 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD Pinto Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13806 Maple Tree Lane SW, P.O Box 43 21556 USA ral", or items 2 Examiner mus death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married Yes 2 X No permit. Page 1 and 2 should be filed within 72 hours after 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" 3 Divorced white Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Construction Supervisor <u>Westvaco</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dorothy Moreland Paul Norman Yoder and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13806 Maple Tree Lane SW, P.O Box 43 Pinto MD Department of Health an Important: If item 27 is any injury or other trau 21556 MD Pinto Pat Yoder wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2X Cremation 3 Removal from State 10/4/2012 Scarpelli Funeral Home, P.A. MD 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown Signature of Funeral Service Lio 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as the t IE FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Pregnant at time of death Other (specify) Month Day Year signed by the a d be detached f 1 Yes 2 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s performe 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Tes 2 No 1 Department 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Yes Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 □ No Accident Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) ,0 person who completed cause of death (Item 23a) (Type, Print) brook, Kd. Ste. 380 Cumberland, MD 2502

Registrar
DHMH 17 Rev 06-2011

State

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 900 PM Physician/ Allen Anna Α. Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Bei Av Herefu and Fur 8. Date of Birth (Month, Day, Year) Jan. 30, 1921 If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-18-6452 Hours 91 □ M 2 1 F MD Director 28a-f show 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director MD Harford Joppa 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21085 USA Funeral 1 Old Sound Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry
Economic Commission Office Assistant Elementary/Secondary (0-12) 12th College (1-4 or 5+) of Harford County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theresa Reinhart John Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue Tyber /daughter 1 Old Sound Road Joppa MD 21085 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Belair Memorial 10/17/12 Belair MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility 300 Mace Ave. 21. Signal Balto. Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy or Attending Physician: The law death? certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4

✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ within 24 hours after dearn.

To the Funeral Director: After this is the funeral director of the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gertifying Nurse Practitioner: To the best of my knowledge. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

Kerrage

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1 6 2012

-M. Δ . 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

D20242

615 W. MACPHAIL RD #106, BEC AIR

115/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year GIRL LINDA AYESU Medical 2.01ΛΔ 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson <u>Baltimore</u> 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Hours Months Days Min. (Month, Day, Year) Director NONE 1 M 2 V F 24 10/8/2012 MD Usual Residence of Decedent 28e-f shov 10a. State treumetic event, the Medical Examiner must be notified et 10c. City, Town or Location 10d. Inside City Limits Director OWINGS MILLS BALTIMORE 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23e USA 9403 HIGH ROCK WAY 21117 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 ☐ Married ۾ AUNI Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "neturei", 3 Widowed 4 Divorced Specify: BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 hand Mental Hygiene.
7 is marked other then "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) INFANT INFANT AYESU, GIRL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Pege 1 and 2 should be Department of Health end Ment Important: if item 27 is marke eny injury or other treumetic once. **AYESU** LINDA RICHARD OSER AMANKWAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify Lin state Signature of Lume 1 Service Licenses de 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Medical resulting in death) Due to (or as a consequence of) Examiner 2 hours 24 min term Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physicien: The lew requires that the death certificate be executed attending physician end I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last compet ence Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year signed by the at I be detached for Pregnant at time of death 5 Other (specify) 9 Unknown 2012 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, been sig Completed 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 2 No 1 Yes မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and thie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) OVIC 2109 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, G932, 10/16/2012, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 12 2012 Marie Katie Austin 4:16 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 824 Springfield Circle Wicomico Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours (Month Day Year) 1 🗆 M 2 🗖 F Maryland 215-16-3001 95 **Director** Yrs or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director X□ Yes 2 □ No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 824 Springfield Circle 21804 **USA** 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: 3X Widowed 4 □ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental If item 27 is marked o ည Franklin Joseph other traumatic Elsie Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean E. Dykes / Daughter 1816 Mt. Hermon Road., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Page 1 þ permit. Page Department of Important: If any Injury or once, 4 Donation 5 Other (Specify) Chesapeake Crematory 10/16/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician NARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examine ASC. V Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) Month Year 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Dennis Chodnicki</u> 400 Eastern Shore Salisbury, Md. 21804 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar OCT 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RIBERT BARNES 25 Year 0 10:59 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1+5WARD HOWARD COUNTY CUEN OUR INSPITA CUZUMBIA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 508-34-5849 Director 1X M 2 □ F Aug 20, 1932 Nebraska 80 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10101 Governor Warfield Pkwy. #447 21044 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 5+ Case Manager State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked c ပ John Barnes Elisabeth Kudrna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10101 Governor Warfield Pkwy #447 Columbia, MD 21044 ge 1 and 2 sh nt of Health au : If item 27 is Marilyn Carol Barnes/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If if any injury or o 1 Burial 2 Commation 3 Removal from State Final Journey Crematory 10/15/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Going Home Cremation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville, P.O. Box 784 MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NOSPINATURY AWTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CONCETIVE INTERT RAILURE Diramon Ariso Hours Sequer daily list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): 10 YEARS The law requires that the death certificate be executed CARD wow of ATHY sician and buriat-trans Due to (or as a consequence of): resulting in death) Last Medical as attending I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year ed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chamic obstructive Pulmmay 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No this certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗆 Yes 2 🗔 🛪 6 မ 1 Monpatient 2 ER/Outpatient 3 DOA 27. Manner Jeath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred atural 5 Pending Accident Suicide thin 24 hours after death.
the Funeral Director: Afortpletely filled in by the fu 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 70 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1) 36974 Dansery OUT 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

MO. 10710 CHARTER DRIVE, COLUMNIA

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Funeral		5. Social Security Nu	ımber	6. Sex	7. Age	(In yrs. last	birthday)	If Un	der 1 Year	r If Under	r 24Hrs.	8. Date of E	irth (MM/	DD/YYYY) 9.	Birthplace (State or
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	nd 2 shou ealth and m 27 is n		19a. Informant's Name/Relationship (Type, Print) Garrison Black - son		o. Mailin	g Address (Street a.) 3 River	nd Number of Bay Ro	or Rural R 1; An	napoli	; City or Town, LS, MD 2	State, Zip (21409 	Code)		
altimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☑ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place	a)	Date	e	20c. Location	- City or To	own, State		
Balt	permit. Departi		21. Signature of Finera Conal ade	Virector	22	Name and Address						21201		
ı			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do	not ente							Approximate Interval Between		
~	Physician/	0 10	Immediate Cause (Final disease or condition	NOSTAGE	COM	JGESTIVE	- HEA	FET	FAIL	WIRE		VEARS		
	Medical Examiner			e to (or as a consequence	of):									
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence	of):									
_	ate be executed physician and the burial-transit	edical Exa	that initiated events resulting in death) Last	e to (or as a consequence	of):									
3760	ficate g physas the	/ledi	- d					•						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal deat Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)	у				23d. Date of delivery Month Day Year			
P.0	s that thighed by	by Pr	Part II. Other significant conditions contributing RENAL IBSUFFICE	-	in the u	nderlying cause giv	en in Part I.					ne cause of death?		
rds	equire	eted	VENOUS STASIS		١ ،	011		_	24a. Was			psy findings available		
Records, P.O.	sician: The law is certificate has k	Compl		WELL &	4(1	01~			autor	rmed?		mpletion of cause of		
ita	sician: certifi rector	m	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Othe	r: Death	,						
of <	Physer this eral di	e: 10	27. Manner of Death 28a.		Time of	28c. Injury	at			lence 6 Oth ow injury occur				
ono	Attending Physician: Ther death. ector. After this certificat by the funeral director, pa	ficat	2 Accident Investigation	(Month, Day, Year)	injury	work′ M 1 □	? Yes 2□N	No						
Division of Vital	e Hospital or Attendi n 24 hours after death. e Funeral Director, A sletely filled in by the fi	l Certificate:		Place of Injury - At home, fouilding, etc. (Specify)	arm, stre	eet, factory, office		28	f. Location (S City or Tow		oer or Rural	Route Number,		
	To the Hospii within 24 hour To the Funer: completely fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the 3 Certifying Nurse Practite	e basis of examination and/	or invest	tigation, in my opinio	n, death occi	curred at the	e time, date a	nd place, and di	ue to the ca	use(s) and manner stated.		
	North		29b. Signature and title of certifier 1 4 HOWE N	D		29c. License	number 3700			29d. Date signe	_	Day, Year)		
			30. Name and address of person who completed 154	cause of death (Item 23a)	(Type, P	N ST.	N	1667	ams	PORT	M	>		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 6 2012	32. Registrar's Signature	we	,								

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#20a-c, 22perFH, G932, 10/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 1 2 33042 - State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) September 30, 2012 Physician/ 5:35 Rose Louise Barker Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges College Park 9734 51st Avenue Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral Director** 305-32-0636 1 M 2 TXF 90 June 2, 1922 Germany Usual Residence of Decedent or 28a-f show be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. Count with the Maryland Director 1 Yes 2 No College Park Prince Georges 10g. Citizen of What Country? 10f. Zip Code 20740 10e. Street and Number er than "natural", or items 23a of the Medical Examiner must be 9734 51st Ave. Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give þ 3altimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) chief teller Sun Trust Bank Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Munkel Ludwig Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 5206 Charnwick Ct; Houston, TX 77069 Marilyn Sigler - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Hother (Specify) 17 State 10-17-2012 Glen Burnie, MD Atlantic Crem. 22. Name and Address of Facility State Anatomy Board
Simplicity Cremation an Funeral Services
7090 Ridge RD Hanover, HD
Approximation Sicenstane, Signatu Director RD Hanover, 7090 Ridge 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the meshock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (callolados Neplaon Immediate Cause (Final Ph_sician/ disease or condition Medical Examiner resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No 1 Yes 2 L g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably XX Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 🗌 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined

Division of Vital Records, P.O. Box 68760

Certificate: Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 8116

Good Luch Rs. #300, Lonhom

(0)

State

Don

Date filed (Month,

1 6

Registrar

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death tobe Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northwest Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Ct 4 1950 1 M 2 XF 62 **Director** 213-54-0497 Oct Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho idical Examiner must be notified at Director MD Baltimore 10e. Street and Number 10f. Zip Code Funeral 2121 Windsor Garden Lane Apt 301 21207 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) <u>Union Representative</u> and Mental Hygicis is marked other Be Department of Health and Mental H
Important: If item 27 is marked oth
any Injury or other traumant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ John Wise Celestine Dukes 19a. Informant's Name/Relationship (Type, Print) Dawnyell Taylor - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date King Helde of Disposition (Name of King Helder or the Polar On Site Cremato 1 🗷 Burial 2 🛣 Cremation 3 🗆 Removal from State Oct 16 2012 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March Funeral Home West, Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or is a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due (or as a consequence of) law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy φ in the past 12 months? 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, should 24a. Was an page 2 s has performe 2 N Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No မ ER/Outpatient 3 DOA 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No tal or Attending Programmers after death.

al Director: After the director is the funeral and its programmers. Certificate: Natural injury 5 Pending М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined To the Hospital or within 24 hours a To the Funeral D the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Prin

State Registrar

DHMH 17 Rev 7/2009

Old Ct.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20a7c perFH.G932.10/16/2012 WS
State of Maryland 7 Department of Health and Mental Hygiene

9. Birthplace (State or Foreign

Day

Reg. No.

1855

2012

4c. County of Death

Baltimore

10d. Inside City Limits 1 Yes 2 No

10g. Citizen of What Country?

USA 14. Race - American Indian

Black, White, etc. Black

Univ. of Maryland

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9611 Fable Drive Owings Mills, MD 21117

20c. Location - City or Town, State Woodlawn Baltimore, MD

4300 Wabash Ave. Balto.

Approximate Interval Between Onset and Death

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Mnknown

24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month-Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Patuxent River Health & Rehab. Laurel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 KF Days Hours Min. 215-24-7824 Director 21 05 Usual Residence of Decedent 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location Director MD NA Baltimore ò 10e, Street and Number 10f. Zip Code Funeral items 23a 3305 Leighton Ave 21215 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify. Completed 3 XWidowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 of Health and Mental Hygiene.
 fitem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Educator 12th grade 5yrs+ Be 17. Father's Name (First, Middle, Last) Thomas Winslow Elnora Perry 19a. Informant's Name/Relationship (Type, Print) Daughter Department of Health a Important: If item 27 is any injury or other tra 11716 Balsamwood Terrace, Laureen Burton-Kendrick Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/18/2012 Woodlawn 21. Signature of Funeral Service Licensee March Address of Facility t 23a. Parl 1. Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line imp diate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Completed by Physician/Medical Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Pregnant at time of death 1 Yes 2 g 2 No detached 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Physician: The law requires Records, 24a. Was an this certificate has pade performed? Yes 2 N **Division of Vital** Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the Certificate: Natural 28b. Time of 28c. Injury at 5 Pending work 1 🗌 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined To the Hospital within 24 hours a To the Funeral I Medical 29a. Certifier only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type_Print) a DAVE

4c. County of Death Prince Georges Birthplace (State or Foreign Country) 10d. Inside City Limits 1 X Yes 2 No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business Industry Baltimore City Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, Md 20708 20c. Location - City or Town, State Woodlawn, Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

12:10p^M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ SALECUSKI 2.24 M ENTRUPE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 9. Birthplace (State or Foreign Country) 26 Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Hours November 214-22-7333 15 1926 ° Director 1 □ M 2**X** F 85 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Maryland Anne Arundel -28a-f Pasadena 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Completed by Funeral 23a 7903 Whites Cove Road 21122 USA f Health and Mental Hygiene. Item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: white Specify: 3 Novidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) <u>0</u> Andrew Uzarowski Mary Waikoski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter Sandra M Haas 7903 White Cove Road Pasadena MD 21122 or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth cemetery, crematory or other place)

Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 10/18/12 Glen Burnie Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Fuenral Home P. A. 3111 Mountain Road Pasadena MD 21122 Part 1. Enter the dis shock, or heart failure har caused the death. Do not enter the mode of dying, such as cardiac or respiratory reach line. 23a Part 1 ase, or complication Immediate Cause (Final Onset and Death Premision disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine If any leading to immediat cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown Month Day Year page 2 should be detached 1 Yes 2 2 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of I or Attending Physician: The law after death.

Director: After this certificate has autopsy performed death? 2 No 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lung blen Borne

Registrar

(Check

29b. Signature and title of certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33046 State of Maryland / Department of Health and Mental Hygiene 🤈 1 - For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ MOTO BER DA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 timore 8. Date of Birth ge (In vrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min 47 219-86-1037 Director 1 **X** M 2 □ F 12-19-64 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21213 1538 N. Caroline Street **USA** items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian 12 should be filed within /z nouncemath and Mental Hygiene.
n 27 is marked other than "natural", or iter Examiner Black, White, etc. African by 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) NA Elementary/Secondary (0-12) Nursing Home 12th Grade Dietary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Cleallor Dunlap Banks William other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
821 N. Payson Street Baltimore, Maryland 21217 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is range any injury or all Deborah L. Banks-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 10-17-12 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Pseudomonas reumona disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pseudomonas bactuemia Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examir Cause (Disease or injury that initiated events resulting in death) Last Yoly microbial preumoria and Due to (or as a consequence of) physician Physician/Medical that the death certificate be P.O. Box 68760 the attending IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death be detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an page 2 s autopsy has death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify ဂ္ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide upletely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number Htsina wame 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATSINA DRIEANS St. BAltimORE MD 31. Date filed (Month, Pay, Year) 0CT 1 6 2012 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:15 PM October 12, 2012 Ruth Catherine Boyle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Oakcrest Village Parkville Baltimore Birthplace (State or Foreign Country)
_ 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year)
Jul 25, 1 Days Hours Min. 92 Director 1 M 2 K 1920 Maryland 212-09-4784 ual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the <u>Medical Examiner must be notified at</u> 10a State 10b. County 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8832 Walther Blvd. unit S107 21234 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give à 21215-0036 1 Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 George Krauk Wilhelmena Johanna Oltman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a William A. Boyle, III /Son 3822 Bayville Road Middle River, MD 21220 Department of Healti Important: If Item 2 any injury or other t injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct 15 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 M01443 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ cerebial disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner TSCVO Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ig physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 cate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate is completely filled in by the funeral director, pag 2 🗆 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🖪 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 2ga Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier eme D78640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anna Walther no 8500 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	Ce	rtificate of Death	1	Reg. No. 2012	33047			
Physic Med		1. Decedent's Name (First, Middle, Last) ABLAHALL BEL	MAN SKI		2. Date of Dea Ocross		3. Time of Death /:60 P M			
Exam	iner	4a. Facility Name (if not institution, give street and r FUTURECARE CHERRYWOOD	umber)	4b. City, Town, or Locatio	OWN	4c. County of Death BALTIMOR				
Funera Directo	_	5. Social Security Number 285-28-6048 Usual Residence of Decedent 6. Sex 1 ☒ M 2 □	84	Months Days Hours	ler 24 Hrs. 8. Date of Birt (Month, Date of Min. 03/23	/, Year) Coun /1928	POLAND			
e Maryland r 28a-f sho notified at	Funeral Director	10a. State 10b. County MD BALTIMORE 10e, Street and Number	10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🛣 N				
/ith th	la l	6 BRIDLE COURT		21136		10g. Citizen of What Cour USA	ntry ?			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ğ	11. Marital Status 1 □ Never Married 2 🏋 Married 1 및 💢 Social Status	Forces?	Was Decedent of Hispanic (If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☒ No Specify Cuban, Mexic	can, Puerto Rican, etc.)	14. Race - Americ Black, White,				
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	Completed	3 Widowed 4 Divorced Year of	Dates.	dent's Usual Occupation		16b. Kind of Business/In	dustry			
215 n 72 h san "n Medi	ld m	(Specify only highest grade complet	ed) (Give	kind of work done during m OO NOT use retired)	ost of working	Top. Kind of Eddinoso/in	dustry			
ygiene ygiene ther th	Be Co	12		OWNER		LINEN	SUPPLY			
and pe filed antal H ked of	To B	17. Father's Name (First, Middle, Last) JOSEF	BERMAI		other's Name <i>(First, Middl</i> e, HAYA SURA BI					
aryl nould b		19a. Informant's Name/Relationship (Type, Print)		ing Address (Street and Num			Code)			
, Manda sha sha sha sha sha sha sha sha sha sh		DANA FARBMAN/DAUGHTER	36	90 ASHLEY WAY	, OWINGS MII	LLS, MD 2111	7			
Jore Je 1 ar It of Ho If iter		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal fr	JIII State	matory or other place)	Date	20c. Location - City or To				
Itim	al l	4 Donation 5 Other (Specify) 21. Signatur of Juneral Service Licensee	BALTIMO	ORE HEBREW	10/15/2012	REISTERST				
Ba perm Depa Impo		21. Signature of numeral Service Licensee		2. Name and Address of Fac 8900 REISTE	RSTOWN ROAD,					
Physician	,	23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition			as cardiac or respiratory an	rest,	Approximate Interval Between Onset and Death			
Medica Examine	_	reculting in death)	to (or as a consequence of):							
		Sequentially list conditions, if any, leading to immediate Due	to (or as a consequence of):							
rted d ansit	Examiner	Cause (Disease or injury	((
760 cate be executed physician and sthe burial-transit	Medical Ex	that initiated events resulting in death) Last	to (or as a consequence of):							
68760 ertificate be ding physic		IF FEMALE: 23c If yes	outcome of pregnancy							
Box 687, ne death certifica the attending place of ched for use as t	nysician	in the past 12 months?	ve Birth 2 🗌 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year			
ords, P.O. Box 6 requires that the death cer been signed by the attendi should be detached for us	ed by PI	PARKINSON & SEA		underlying cause given in Pa		obacco use contribute to the Yes 2 No 3 Pro	1/			
2 88 5	Completed by Physician				24a. Was auto perfo 1 □ Yes		psy findings available mpletion of cause of 2 No			
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of VI	6: 일	27. Manner of Death 28a. D	Inpatient 2 ER/Outpatient 28b. Time of	of 28c. Injury at	Nursing Home 5 Residual Residu	dence 6 Other (Specify now injury occurred)			
ath.	icate	2 Accident Investigation	fonth, Day, Year) injury	work? M 1 ☐ Yes 2	□No	. ,				
Divisic tal or Atte rs after de al Directol led in by th	al Certificate:		ace of Injury - At home, farm, st ilding, etc. (Specify)	reet, factory, office	28f. Location (S City or Tov	(Street and Number or Rural Route Number, wn, State)				
Division of Vital Rec To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the (Check only one) 3 Certifying Nurse Practition	basis of examination and/or inve-	stigation, in my opinion, death e, death occurred at the time,	n occurred at the time, date a date and place, and due to	and place, and due to the ca the cause(s) and manner as	use(s) and manner stated. stated.			
P With		29b. Signature and title of cartifier	ause of death (Item 23a) (Type, 7.0, 80 x 26	29c. License numbe		29d. Date signed (Month, OCTOBEL 10	-			
		30. Name and address of person who completed of	ause of death (Item 23a) (Type,	13 Salis Louis	u WALLIAI	A 21802				
S	tate		Registrar's Signature		11,-11,070					
Regis	trar	OCT 1 6 2012	A. par	7-						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A M Dilli Ram Baral 2012 3:14 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5001 Raintree Way, Apt. K Baltimore Social Security Number If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country) India Days (Month, Day, Year) 04/19/1932 1 M 2 □ F Director 212-87-6101 80 Usual Residence of Dece 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 5001 Raintree Way, Apt. K 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Data Ram Baral 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any Injury or other trai once. Puspa Lal Baral / Son 5001 Raintree Way, Apt. K, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Atlantic Crematory 10.16.2012 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown be detached 9 Unknown P.O. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, cate has been sig ; page 2 should t Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe To the Hospital or Attending Physiclan: The within 24 hours after death.

To the Funeral Director: After this certificate is Yes 2 No 1 Yes 2 No Division of Vital filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 The Residence 6 Other (Specify) 1 Yes 2 💆 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 - Pending work? 1 🗆 Yes 2 🗆 No Matural 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier (Arcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 3 □ death (Item 23a) (Type, Print) 30. Name and address of person who complet ENTIERY /Ve 7940 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3305 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Blum Charlotte Mae 4:2/AM Medical 4a. Facility Name (if not institution, give_street and number) Examiner Town, or Location of Death 4c. County of Death Itimo 8. Date of Birth
(Month, Day, Year)
July 28, 1943 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 X F Min. 219-40-5937 69 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Ħ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director any injury or other traumatic event, the Medical Examiner must be notified Centerville 1 Yes 2 XNo Queens Annes Maryland 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 158 Edenderry Avenue 21617 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 0 Black, White, et ρ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Call Center Secretary 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Walters Charles Frederick Weber Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 158 Edenderry Avenue, Centerville, Maryland 21617 Sheri Lee Desmarais Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 Burial 2 XCremation 3 Removal from State Baltimore, Maryland 12, 2012 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Ansee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a, Part 1 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death k, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ EPT Medical Due to (or as a consequence of): Examiner XTRE MITY CELLULITIS UTI OWER Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b END STAGE RENALDISEASE, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **W**No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 29b. Signature and title of certifier 29c. License number Snown 29d. Date signed (Month, Day, Year) 000 RES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLVD, BALTIMORE, MD ABHISHEK SHARMA, 5601 LOCH RAVEN BLVD, BALTIMORE, MD POW

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 6 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6 Month Physician/ 135 AM Margaret R. Brown 201 Medical 4a. Facility Name (if not institution, give street and number) 46. City Town, or Location of Death Examiner 4c. County of Death AGNES _TIMORE BAL Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) **Director** 220-07-1762 1 M 2XXF 88 yrs July 8, 1924 Maryland or than "natural", or items 23a or 28a-f show the Mucked Evar-ings must be notified at filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Halethorpe 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1707 Rittenhouse Ave. 21227 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2XX No Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Tes XX No Specify 3 XWidowed 4 ☐ Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9grade Housewife Own Home Be permit. Page 1 end 2 should be filed Department of Health and Mental Hy Importent: If item 27 is marked oth eny Injury or other treumetic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Fitzpatrick William Montgomery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3360 Warren Ct., Westminster, Maryland 21157 19a. Informant's Name/Relationship (Type, Print) Margaret Jones/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Oct.13,2012 Atlantic Crematory Glen Burnie, Maryland 4 Donation 5 Other (Specify) Sign e of Fineral Service Licensee 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final hrouic Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): use as the burial-transi the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The lew requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Þ in the past 12 months?
1 Yes 2 No Month be detached 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Records, 1 Yes 2 No cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No 1 Yes Division of Vital 25. Was case referred to medical ROUN Certificate: To Be 26. Place of Death (Check only one) 1 🗆 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of p Wish der casa 31. Date filed (Month-Dev. Year) State Registrar

DHMH 17 Rev 06-2011

MARGER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 0001 20: i0 OC-t Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Cen Number J. Sex 7. Age (In yrs. last Baltimore **Funeral** Birthplace (State or Foreign Country) 8 Date of Birth Months Min. Director 1 □ M 2 🗹 F 65 Maryland marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location Director event, the Medical Examiner must be notified 1 Yes 2 No timor 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced 4 Divorced Blac Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Maryland Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important; If item 27 is marked o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapper - Worden 20b. 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) injury 4 Donation 5 Other (Specify) Name and Address of Facility of Funeral Service Licensee بخى 23a. Part 1 Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 5(6)aru disease or condition Medical resulting in death) Due to (or as a cons dence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 \sum Yes 2 **N**o မ 1 Ninpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After To the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 1063 Obe 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Greene St. 12 , Baltimore, MD 16 Registrar

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900	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Item Marchal Examiner must be notified at	ρ	1 ☐ Never Marrie 3 ☐ Widowed 4		Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	No 195	72-			n, Mexican Specify:		ican, etc.)		Blac Specify:	k, White,		
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2	nd 2 shou ealth and m 27 is m			Covingtor			19b. Maili 2	ng Addres Monta	s (Street a	and Number	Balt:	Route Numb imore,	er, City o MD	2120	state, Zip (8	Cade)	
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	be executed sician and burial-transit	cal Examiner	Sequentisty list co- if any, leading to im- cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	rlying injury s	Due to (or as Due to (or as	a conseq	uence of):		-								
Ø 69760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	al death 3	Ectopic Other (s		ey .					te of deliv	1	Year
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	ne Hospital or in 24 hours afte e Funeral Dir	Medical	(Check 2	Medical Exa	hysician: To the best of miner: On the basis of curse Practitioner: To the	examinatio	n and/or inves	stigation, in	my opinio	on, death or	ccurred at t	he time, date	and plac	ce, and du	e to the ca	use(s) and ma	anner stated.
4	To the company of the		29b. Signature and the Ahmod	4 .	H. MD				c. Licens	e number 428						Day, Year)	
			Ahmed Ab	xdela ziz	o completed cause of c	. Cat	on au	e I		nore	. , ~	10 0	212	29			
	St Regist	ate trar	31. Date filed (Mont)	CT 1 6 2	012 38 Registr	ar's Signa	ture for	Ke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 8:40 A M Elwood P. Cassell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare Hammonds Lane Anne Arundel Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 💢 M 2 🗆 F Months Days Hours 06-26-1918 204-03-4091 94 Pennsylvania **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director Linthicum Maryland Anne Arundel 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 "natural", or items 23a o Funeral 21090 311 Ardmore Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces 1 Never Married 2 K Married 1 X Yes Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Standard Wheel and Rim Branch Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Ernest Cassell Sr. Lida Shuey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a item 27 i Ardmore Road, Linthicum, Maryland 21090 Betty Cassell/Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite è 1 X Burial 2 Cremation 3 Removal from State 10/18/2012 Glen Burnie, Maryland injury 4 Donation 5 Other (Specify) Glen Haven Mem. Park 22. Name and Address of Facility Kirkley-Ruddick Funeral Home ral Sar Act Lionni ee Signatir 421 Crain Highway SE, Glen Burnie, Maryland 21061 23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death disease Immediate Cause (Final Physician/ Cerebrovasc lears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to lor as a consequence of cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and rother funeral Director prompleted filed in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) Pregnant at time of death 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) f Death 27. Manne 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred l atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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State Registrar riation Blud Glen Burnie MD 2106,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ OCTOBER. 10,2012 3:30 P LESLIE FRANCIS COLLINS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST BALTO. TOWSON If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Months Days Hours Min. Country) 218-22-7334 1 M 2 D F Director 84 MARCH 5,1928 MARYLAND Usual Residence of Deceder 10a, State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23e or 28e-f sho within 72 hours after death with the Maryland Director BALTO. **NOTTINGHAM** 1 Yes 2 No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4227 DARLEIGH ROAD 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No If Yes, Give þ 1 Never Married 2 TMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 1945-1949 al Hygiene. d other then "natura" event, the Madical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE CITY POLICE OFFICER Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event 9002. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GERTRUDE M. SCHULTZ LESLIE N. COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID M. COLLINS SON 661 TOWN BANK ROAD N. CAPE MAY .NJ 08204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) MOST HOLY REDEEMER 10-13-2012 BALTO. MD. 21206 21. Signature of Funeral Service License 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. Stefanio 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ LUNG Savamous Morths disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 D Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 ☐ Yes 2 De No 1 ☐ Yes 2 ☑No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 10 Other (Specify) Wes pre-2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOSOR 11 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 140 Utnues 4ARON 6201 N. Charles M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ OCTOBER 13, 2012 2:05 A M G COHEN RUTH Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE 11 SLADE AVENUE, BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthdav) **Funeral** Days (Month, Day, Year) Director 217-38-8274 1 □ M 2 🗓 F 09/12/1935 MD 77 Usual Residence of Decede ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Marylend Director 1 Yes 2 1 No BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 11 SLADE AVENUE. #107 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give Specify. 3 Divorced Completed WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) **EDUCATION TEACHER** 5+ and Mental Hygien Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **GERTRUDE** MARCUS permit. Page 1 and 2 should be Department of Health and Meni Importent: If item 27 is marke any Injury or other traumatic once. H. GABRIEL GLICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 SLADE AVENUE, #107, BALTIMORE, MD LESTER COHEN/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM. 10/14/2012 REISTERSTOWN, MD 21. Signature of Juneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lymphoma Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{M} \) Residence \(6 \text{ \text{Other}} \) Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending 2 ☐ Accident
3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00050414 oct 13,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10755 Folls Ro, Luthenville, MU 21093 10 JOHN AUCOTT MO, 31. Date filed (Month, Day, Year)

Registrar

OCT 16

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 9:20A M Maureen Ann Dincher 2012 Oct 13 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Manchester Long View Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Min. 1 M 2 X Hours 201-32-6929 70 Director 12-20-1941 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, I'm Medical Examinar must be notified at 1 ☐Yes 2 No Director MD Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2837 Lawndale Rd. 21048 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. ģ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Teacher permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygin Important: If item 27 is marked other any injury or other traumatic event, Item 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur F. Dolan Josephine I. McGee ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Dincher-husband 2837 Lawndale Rd., Finksburg, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Williamsport, PA 4 ☐ Donation 5 ☐ Other (Specify) Wildwood Cemetery 10/19/12 22. Name and Address of Facility Fletcher Funeral & Cremation 21. Signatura of Funeral Service Licensee tother I 254 E. Main St., Westminster, MD 21157 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Azute Cerebrovasc **Physician** minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** ASCUD Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed and -tran resulting in death) Last physician a s the burial-t Due to (or as a consequence of) Box 68760 Physician/Medical 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 □Yes 2 INO 1 ☐Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes within 24 hours after death

To the Funeral Director: A

Completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 037573 October 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 26/3

1304

32. Registrar's Signature

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20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33059 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Year Medical 4a. Facility Name (if not tion, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death pita 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 24 Hrs **Funeral** Min 216-94-5294 **Director** 1 🗆 M 2 🕱 F June 28,1979 33 Maryland 28a-f shov with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 XVo MD Dunda1k Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21222 United States 1848 Church Road death v Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 XMarried 72 hours after Yes 2 **X**No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱No Specify: "natural", Completed 3 Widowed 4 Divorced Specify. White Medical Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " within 7 Elementary/Secondary (0-12) College (1-4 or 5+)
Years 12 Years 4 Dentist Office Office Manager other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental H 27 is marked of traumatic ever ည pe Deborah K. Grace John W. Jackson, Jr. Page 1 and 2 should I ment of Health and M∈ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: If item 27 is any injury or other trau Dundalk, Maryland Mr. Michael R. Dunn (Husband) 1848 Church Road Baltimore, 20a. Method of Disposition ✓ lace of Disposition (Name of) 20c. Location - City or Town, State cemetery, crematory or other place 1 ☐ Burial 2X Cremation 3 ☐ Remova Hilltop Service Corp 10/20/2012 Towson, Maryland 4 Domation 5 Other (Specify) Sign isher .Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Part 1. Enter the disease, or complications that of used shock, or heart failure. List only one cause on each line. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unions that interest in the control of the cause of injury that interest in the cause of injury that interest in the cause of injury ner Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day 1 L Yes No 9 D Unknown Pregnant at time of death be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 X No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident work? 5 \square Pending 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State within 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check etifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MicMael Baydarian, M.D. 301 St. Paul Place Baltimore, Maryland 21202 State Registrar

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e rve A. Dougla		State of Maryland / Department of Health and Mental	2012 330									
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ledical Exami	ner	flerve A. Douglas	October 11, 2012 2240 hrs									
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Do										
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Director		218-82-1066 1 Ym 2 F 51 Yrs. Months Days Hours	Min. 09-26-61 roreign country) MD									
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Wylie Funeral Home P.A.									
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	-	638 N. Gilmor St	reet Baltimore, Maryland 21217									
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardio										
/Medical		failure. List only one cause on each line.	Between Onset and Death									
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C 68	<u>S</u>	past 12 months? 4 Pregnant at time of death 5 Other (Specify)										
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
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Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the it	<u>8</u>	Check only one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
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	29b. Signature and Hitle of certifier 29c. License number O.C.M.E. October 12, 2012											
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:20		30. Name and address of person who completed cause of death (Item 23a)	offimers MD 21223									
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Ba	SIGNOTE, IVID 2 1223									
	tate	31. Date filed (Month, Day Year) 12 32. Registrar's Signature										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3306 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 1-55PM Dolores M. Domowski TOBER 20/2 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE WASHINGTON MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. 90 Director 212-18-2937 1 □ M 2 🗓 F MARYLAND 11-9-1921 Usual Residence of Decede or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at</u> Director 1 Yes 2 No PASADENA ANNE ARUNDEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 8089 CATHERINE AVENUE Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE Specify: 3 X Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MARTIN CATERING 9TH WAITRESS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARY WEBER BENJAMIN DALEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KINGSVILLE, MD. 21087 DTR 3901 MILLER ROAD DOLORES MARTINO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 10-16-2012 MIDDLE RIVER, MD. 4 ☐ Donation 5 ☐ Other (Specify) HILL Signature of Funeral Service Li 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. BALTO.MD. 21224 6224 EASTERN AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SMAL Physician/ OBSTRUCTION disease or condition resulting in death) BOWE DAY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate rause. Fitter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an performed' Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 ☐ ANo 1 Donpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I only one) 29b. Signature and title of certified 29c. License number Eunnalea 006 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 301 HOSP DR GLENBURNIE MD 21061 ARORA HARVINDER SINGH BWMC 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 16 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 12, DIRCKS MTLDRED W. 11:14 PMM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMORE COUNTY NOTTINGHAM 4105 WALTER AVENUE Social Security Numbe 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday **Funeral** 1 M 2 W Hours 2-21-1925 PENNSYLVANIA 204-18-0654 87 **Director** Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director BALTO. MD. **NOTTINGHAM** 1 Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 4105 WALTER AVENUE 21236 **USA** Page 1 and 2 should be filed within 72 hours after death \text{ment of Health and Mental Hygiene.} ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 X Widowed 4 □ Divorced Specify. Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) REGISTERED NURSE VETERANS ADMIN. ed other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname, ၉ SAMUEL WALTO THERESA VOTTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other troonce. TERESA JOHNSON DTR. 11016 OLD LANDING ROAD KINGSVILLE, MD. 21087 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BEL AIR MEMORIAL 10-18-2012 BEL AIR, MD. 22. Name and Address of Facility SCHIMUNEX FUNERAL HOME INC. 21. Signature of Funeral Service Licensee 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acclisallming disease or condition Medical resulting in death) od 12,2012 **Examiner** Sequentially list conditions, Examiner if any hading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the 9 Unknown g Unknown Division of Vital Records, P.O. certificate has been signed by rector, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1-💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MP Redo

Registrar

State

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Herford Red Smite 201 Baltime, MD 21259

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

OCT 1 6 2012

del

Registrar's Signature

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. amend 1tem 12 per 1h g932 10-16-12 vt State of Maryland / Department of Health and Mental Hygiene 20 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death 100 Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Baltimore Randallstown Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours (Month, Day, Year) 07/05/1932 1 M 2 □ F Director 216-30-8923 80 Maryland Yrs is then "neturel", or items 23e or 28a-f show the Medical Evarainer must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Baltimore 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 5129 Nelson Avenue 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 x Yes 2 No Army Black, White, etc. 1 Never Married 2 X Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Transportation other treumetic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be file to and Mentel H marked Roger Dorsey Catherine E. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 end 2 sho of Health end Item 27 is r Sarah L. Dorsey / Wife 6666 Collinsdale Road, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 e Depertment of H importent: If ite eny injury or ot injury or (1 Dunial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 10/15/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ cancer Liver Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir physician and s the burial-transit or Attending Physicien: The law requires thet the deeth certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 9 for use es IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day signed by the a 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>중</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete hes performed? Yes 2 1 ☐ Yes 2 ☐ No hours after death.

Linerel Director: After this certific

ly filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other Specific nospice ဂ္ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funerel C Hospital edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 50057465 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/12/12 Baltimore MD 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S NS IS APA LEMD 2835 Sm1 Th N 703 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

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Physician	Month Day Year										3. Time of Death		
Medical Examine	er	JERMAINE	VENDEL	L DA	ALTON			_		October 1	3, 2012		0120 hrs
	4	 Facility Name (if not institution University Hospital 	n, give street and nu	ımber)		4	b. City, Town, o Baltimore	r Location of	of Death		4c. County o		
	- 5	Social Security Number	6. Sex	7. Age (In yrs	last hirth	day)	If Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Bir	N/.		hplace (State or
Funeral Director		, and the second		7. Figo (iii yio			Months Da				`	Foreign	MARYLAND
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any	_	0a. State 10b. County		10c. Ci	ty, Town o	r Locatio	on					\neg	10d. Inside City Limits
	_ M	ARYLAND N/A						BALTI	MORE				1 Yes 2 No
the Maryland tor 28a-f show iffed at once.	1	0e. Street and Number					10f. Zip Code			1	0g. Citizen of Wh	at Coun	try?
the M		2853 HOLLIN	FERRY RD				2123	30			U.S.A.		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ent of Heatht and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once To Re Commiseed by Funeral Director	1	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Marked Forces? 14. Race - American 15. Was Decedent Ever in U.S. 16. Was Decedent of Hispanic Origin? (Specify Yes or No- Hf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No- Hf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S.											can Indian, Black,
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21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	<u> </u>	7. Father's Name (First, Middle,	Last)		1 10	Turk I	TIT DIG		's Name (F	First, Middle, N	Maiden Surname)		
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Page nent o	- 1	4 Donation 5 Other Sp			METRO	CRE	EMATORY		10-	20-12	BALTIMO	RE,	MARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "unstural", injury or other traumatic event, the Medical Examine. To Re Commissed by I	2	Signature of Funeral Service	Licensee			WII	ame and Addres	ss of Facility BROWN	у сом	MUNITY	FUNERAL	HOI	ME P.A.
		3a. Part I. Enter the disease, or	complications that a	oused the des	th Do not		206 W NO				eet shook or hea	art	Approximate Interval
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Examiner		mmediate Cause (Final disease or condition resulting in death)	a. Multiple (2)										Doda,
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o. l		art II. Other significant condit	ions contributing t	o death but no	t resulting	in the ur	nderlying cause	given in Pa	art I.				the cause of death?
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Records, The law requires ficate has been signage 2 should be										24a Was autop	sy p	rior to co	topsy findings available ompletion of cause of
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cian: 1		5. Was case referred to medica examiner?					26.Plac	e of Death	(Check on	ly one)			
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Division of Vital Records, P.O. spital or Atteoding Physician: The law requires that thrours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact		dete	d not be			m, stree	t, factory, office	building, et		or Town, S	state)		ral Route Number, City
Cospits hours	4 Homicide 4 Homicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,												
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transical Certification: To Be Completed by Physician/Medical E-													
F S S S S S S S S S S S S S S S S S S S	2	9b. Signature and title of certifie		stated.			29c, Licen	se number			29d. Date signe	d (Mon	nth, Day, Year)
		Carol is	talla	u			0.0	.M.E.			October 13	, 2012	2
	3	0. Name and address of person									1		
		Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33065 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. ^{Day} 2012 Year Physician/ 12 1:44p M Michael L. Errickson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Gilchrist Hospice Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Days July 24, 1943 Hours 215-40-7955 Director 1**X** MM 2 □ F 69 th end Mental Hygiene. 27 is marked other then "natural", or items 23a or 28a-f show traumatic event, I've Mental Evanniner must be notified at 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location within 72 hours after death with the Maryland Director Middle River Baltimore MD 1 ☐ Yes 2 🎦 No 10f. Zip Code 21 220 10e Street and Number 10g. Citizen of What Country? 158 Kingston Park Lane Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanic self-employed 9th Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Cole filed 17. Father's Name (First, Middle, Last) Randolph Errickson bef 1 and 2 should b of Health end Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
158 Kingston Park Lane Balto. MD 21220 19a. Informant's Name/Relationship (Type, Print) Judy Errickson /wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gardens of Faith 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it eny injury or o Rossville MD 1 X Burial 2 Cremation 3 Removal from State 10/16/12 4 Donation 5 Other (Specify) ame and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 21. Signatury of Juneral Service Licensee 22. Name and Address of Facility 300 MACE AVE 23a. Part 1. Enter the disease, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition UMONTUS Physician/ METASTATIC Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of: Examine • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the ettending physician end ettending physician end I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Dav 1 Yes 2 9 Unknown ed by the e Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been signer; page 2 should be a ITY PERTENSION 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERLIPIDEMIA 24a. Was an performed 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1489 CO မ 1 Inpatient 2 ER/Outpatient 3 IDOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Klown

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day,

OCT 1 6 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dyr g932 10-16-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0021 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Howard County General Hospital** Howard Columbia If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 213-34-1250 1 □ M 2 😿 F 81 Days Hours Min (Month, Day, Year) Sep 30, 1931 MD **Director** Usual Residence of Decedent show 10a. State 10d. Inside City Limits oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9598 Old Route 108 21042 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "marked other than "marked other than "marked other than "marked other than "marked". 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Postal Carrier 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) **Post Office** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ Norman W. Eckles Mildred L. Gover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 23808 Woodfield Road Gaithersburg, MD 20882 19a. Informant's Name/Relationship (Type, Print) Elsie Kellar 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date St. John's Cemetery 1 Burial 2 Cremation 3 Removal from State Oct 18, 2012 Ellicott City, MD 4 Donation 5 Other (Specify) re of Funeral Service Licen 22. Name Slack Fusieral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 lentede M00535 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death MYOCARDIA Physician INFARCTION Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical death certificate be P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital Other: မ 1 Tes 2 No 1 Inpatient 2 FR/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Oct 13 2012

State

Registrar

parker

5755 Cedar Lane Columbia, Md.

Registrar's Sign

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Samit P. Desai
31. Date filed (Month, Day, Year)

OCT 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 1 per doc 2939 5-16-13 vt 5
State of Maryland / Department of Health and Mental Hygiene 0 1 2 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Deborah E. Wilburn Year 2012 TOATVI PUNCH+ dounty of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death DUNDALK BALTIMORE COUNTY KEMPOINT HomE (O'ROUP | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 18, 1963 219 Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F 49 Yrs. 218-80-8025 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Catonsville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21228 USA 55 Wade Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) N/A Never Worked 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Diane Sherby Wayne Frantz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Towson, MD 21234 23 Skywood Court Wayne Frantz, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 10/15/12 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. Homou 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SUDDEN CARDIAL ARRES Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 2 MELLITUS ABETES Due to (or as a consequence of) YEARS HYPERLIPI 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physicien and s the burial-transit

25 attending for use as

signed by the a d be detached for

this

The law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital or Attending Physician:

To the Hospital

Physician

/Medical

Examiner

10a. State

Direct

Funeral

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Completed

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Funeral

Director

28a-fehow

ir than "natural", or itema 23a or 28a-f ehoi The Medical Examination must be notified at

Ith and Mental Hygir 27 te marked other r traumatic event, II

or other tra

permit. Pag Department Important: I any njury o

Baltimore, Maryland 21215-0036

Examin Completed by Physician/Medical certificate hes t irector, page 2 s Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 10 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. SCHIZOPHRENIA

5moking OF HISTORY

SUBSTANCE 26. Place of Death (Check only one)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24a. Was an autopsy performed? 1 ☐ Yes 22 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case refered to medical examiner?

Yes 2 □ No 27. Manner of Death Natural

5 Pending investigation 6 ☐ Could not be

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

Cther: 4 ☐ Nursing Home 5 ☐ Residence Cother (Specify) GROUP Home Injury at 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

2 Accident

4 Homicide

3 ☐ Suicide

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D 00 19

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HERMAN SPRING GRAVE M.D 32. Degistrar's Signature

State Registrar

Medicai

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ М October 13 1610 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City Hospital Sinai Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days Hours (Month, Day, Year) 407-40-1537 Director 76 1 M 2 X F 20,1936 Kentucky Aug. Usual Residence of Decede 10a, State 10b. Count r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Upper Marlboro 1 Yes 2 X No Maryland Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 10806 Phillips Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Mg Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Dog Groomer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Best Helen Hubert Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10806 Phillips Drive, Upper Marlboro, MD 20772 Angela Foote / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 10/15/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic adeno caremana, unkno 1-27aus Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 D Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) detached q ☐ Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy prior to completion of cause of death? 1 Yes 2 | No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) hospice Other: 4 \(\sum \) Nursing Home \(5 \sum \) Residence \(6 \rightarrow \) Other (Specify) Hospital: 1 ☐ Yes 2 🗗 No |2 1 Inpatient 2 ER/Outpatient 3 DOA CONST To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 037573 October 13, 2012 30. Name and address of who completed cause of death (Item 23a) (Type, Print) bell Po Box MD 21805 Saksbu 2613 31. Date filed (Month, Dav. Year Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mary L. Ford Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral . Social Security Number 212-28-2942 7. Age (In yrs. last birthday) Davs (Month, Day, Year) Director 1 M 2 F New York 84 02/15/1928 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih end Mentel Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Evander must be notified at once. 10b. County 10a. State 10d, Inside City Limits 10c. City, Town or Location Director ty Yes 2 ☐ No N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 124 W. Franklin St. Apt 702 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🐼 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) entary/Secondary (0-12) College (1-4 or 5+) 12th Grade Children Hospital Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unk Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 19a. Informant's Name/Relationship (Type, Print) Felicia Woodfork (daughter 5902 Franklin Ave., Apt 1B, Baltimore, MD 20b. Place of Disposition (Name of cernetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State on-site Crematory /0/0% Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee おめずきかれがHss 野行でWn Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or conditio resulting in death) ANCHEMIC Medical Due to (or as a consequence of) Examiner UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The lew requires that the death certificate be executed this certificete has been signed by the attending physician end real director, page 2 should be detached for use es the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4 Pregnant at time of death 9 Unknown 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 Inpatient 2 PER/Outpatient 3 I DOA 24 hours after deeth.

Funerei Director: After this letely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury ☐ Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: It the basis of my knowledge, death occurred at the time, date, and due to the cause(s) and manner as stated (Check within 2 To the i only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/3/12 a/lo

Registrar
DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item)23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33070 Certificate of Death 2. Date of Death Physician/ Louise Elizabeth Furches October 2012 2:38 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 X F Days Hours Min. Gountry) Maryland 220-24-9451 **Director** 82 Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector MD Harford Bel Air 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Dr #337 21014 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🙀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 ☐ Widowed 4 🙀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) healthcare nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Thurman Monk Mary Elizabeth Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1128 Poplar Grove Rd; Street, MD 21154 Steven Furches - son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Sign of Funeral Service Licen-22. Name and Address of Facility State Anatomy Board Ronald Socie 655 W. Baltimore St; Baltimore, MD 21201 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, be heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PNEVMONIA, Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RIGHT TEMPORAL LOBE STROKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami PERTENSION Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EMBOLUS UL MONARY Records, 1 ☐ Yes 2 PNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 🗌 No 1 🗌 Yes 2 🖁 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this o 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Division within 24 hours after death

To the Funeral Director: A

completed filled in by the f Accident Investigation 6 Could not be ⊒ Accider ⊐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) DOP096 OCTOBER 11, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

ANDREW NOWAKONSKI

31. Date filed (MOCT)

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2. Registrar's Signature

AVE. BELAIR, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 2012 Physician/ Day Pau1 Elmer Fort 7:30 P M Oct. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 219-22-2451 Usual Residence of Dece 1 X M 2 □ F Yrs. July 20,1928 Maryland er then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Dundalk 1 Yes 2 XNo MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21222 United States 3401 Yardley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Completed Year or Dates. Korean White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If Item 27 Is marked other then ' Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing 9 Years Pipecover other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Pauline Richardson Horace James Fort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1901 Robinwood Road Dundalk, Maryland (Son) Douglas E. Fort 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1
Depertment of
Important: If It
any Injury or o 1 X Burial 2 Cremation 3 Removal from State Sacred Ht. of Jesus Cem. 10/12/2012 Dundalk, Maryland □ Donation 5 □ Other (Specify) 21. Sign ure of Funeral Service Licensee Demis 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonar - 15/05 (3 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner hestusis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami the attending physician and thed for use as the burial-transit or Attending Physicien: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by icate has been sig 1 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No s after death.

Director: After this certific of in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗆 Nursing Home 5 🗆 Residence 🗞 Other (Specify) 🕠 ριφ Hospital: 1 🗌 Yes 2. No မြ 1 Inpatient 2 ER/Outpatient 3 II DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by hours after determined To the Hospital o within 24 hours af To the Funerel Di completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS 8303 OCFOSE 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARIES No Changes ST TOUSON MO 6701 M

Registrar

32. Registr s's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cer	tificat	ate of Death Reg					Reg. No. 2012 33016			
	Dharisis	-,	1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath Day	Year	3	. Time of De	
	Physicia Medic	al	Audrey Fitzgera							Scrober			2	4:36	, P M
	Examin	er	4a. Facility Name (if not institution, give str					Location of I	Death			County of Dea	th		
	100		Union Memorial				Ltime					I/A			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday)	If Unde Months		If Under 24 Hours	Min.	 Date of Birt (Month, Day 			thplace oun <i>try)</i>	e (State or Fo	oreign
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ĭ	2 sho th an 27 is trau	ĺ	Pa. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Kevin H. Brockett, Sr.1—Son 3905 Fordleigh Rd. Apt.C Baltimo												215
စ်	and Heal tem		20a. Method of Disposition	20b. P	lace of Dispos	sition (Na	me of		Da			ation - City o			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 R	SINOVALIBOTH GLACE	emetery, crem				0/15	1201) Day	.4.11	a L o	v = N	(D
Ė	artme ortar injur		4 Donation 5 Other (Specify) King Memorial Pk. 10/15/2012 Randal 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East											WII , IV	
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	Examiner			In the setting	a of Ir	Hers	titia	1 Pull	mon	ary Fi	bros	515	10	-15 ye	ars
		iner	Sequentially list conditions, It any, leading to immediate cause. Enter Underlying	Due to (or as a consequ						0					
	uted Id ransit	Examiner	Cause (Disease or injury that initiated events												
	exec an ar urial-t	<u> </u>	resulting in death) Last	Due to (or as a consequ	ience of):								1		
90	cate be executed physician and s the burial-transit	Medical	d										-		
8760	rtifica ing p		IF FEMALE:												
9 ×	th ce ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 	l death 3		pregnancy	y			2	3d. Date of de Month	elivery Da	y Yea	r 1
B	e dea the a hed f	Physician/	1 Yes 2 No	4 Pregnant at time of c	ieath b L	Other (s	респу)							,	
o.	at the		Part II. Other significant conditions conf	ributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco us	e contribute t	o the c	ause of deat	h?
ω, T	signe d be	d by								1	Yes 2	No 3 □ F	Probab	ly 4 🗌 Unl	known
ğ	requi	ete								24a Was	an	24b. Were a	utopsv	findings avai	ilable
၁၁၉	has ge 2 s	Completed	autopsy prior									prior to death?	compl	etion of caus	se of
m m	n: The ficate or, pag												_l No		
/ita	sicial certi lirecto) Be	evaminer?	spital:	ED/0: 44i		Otho	r.			c l	Other (Cas	aiful		
£	r this		1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 6 Other (Sp.												
n C	So general description 1 Natural 5 Pending (Month, Day, Year) injury work? 1 Yes 2 No No No No No No No N														
Sic	Atte	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, facto	ry, office		2			Number or Ri	u <i>ral R</i> o	ute Number,	
Division of Vital Records, P.O. Box	s after s after all Dir	Ö													
	lospit hour unera	Medical	29a. Certifier (Check ((s) and manne	er stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Me	only one) 3 Certifying Nurse	Practitioner: To the best of n	ny knowledge,	death oc	curred at th	ne time, date	and plac	e, and due to	the cause(s	and manner	as state	ed.	
	5 wit 5		29b. Signature and title of certifier	5			c. License		.			signed (Mon			
	9.7		Hara (Kinoman) H				1 21	13894	10		00101	Der Dy	, 2		15.
10	6V		30. Name and address of person who cor				Pari	CUMON	Sime	a Are a	ard a.	BINA	Bal	212	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signar		-011	7.00		SUIT	c 703,.	22 23		العدال.		
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32. Registrar's Signature

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Beautificate of Death

Per FH G932 10/19/2012 JH

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beautificate Of Death For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ZO12 Month moth ames erguson 11:10 OLM Medical acility Name (if not institution, give street and number) 4b. City **Examiner** Town, or Location of Death 4c. County of Death Sai Baltimore Hos 0 seda ranklin Center lare. pita 6. Sex Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1-4357 Months Min. Hours 1 XM 2 □ F **Director** Usual Residence of Decedent 10a. State 10b. County with the Maryland at 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No er guson, Timothy 10e. Street and Number ò 10g, Citizen of What Country? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a one ince. Funeral USA death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) mployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barain MCC Lerguson 102011 19a. Informant's Name/Relationship (Typ , Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi., Code) Barain Ferauson-Brother 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State centingenMemorial 4 ☐ Donation 5 ☐ Other (Specify) 10/19 Italethorpe. 2012 21. Signature of Funeral Service Lice 22. Name and Address of Facility March FlH-East nam 1. Mella North OE. Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Res Physician/ pirator disease or condition Medical resulting in death) a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated supering Examine for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ☐ Yes 2 L ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 1 No 3 Probably 4 Unknown ils certificate has been si director, page 2 should i 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 No ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending Natural work? death. 2 🗌 No Accident Investigation 24 hours after deat Funeral Director. 6 ☐ Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 trai 14/2012 W36663 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Frank Baltimore 000 Drive MD 32. Registra is Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Louis H. Fort Physician/ 5:33KM 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE COURTLAND GARDENS BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours 0970871911 CZECHOSLOVAKIA Director 213-28-6273 101 Usual Residence of Deceden ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No BALTIMORE MD OWINGS MILLS 10e. Street and Number 10g. Citizen of What Country? Funeral 4730 ATRIUM COURT, 21117 USA death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🕅 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) FLOOR COVERING INSTALLER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **PEARL** ICKOVIC FROJMOVIC ABRAHAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a: Important: If item 27 is any injury or other trau 10330 BASSETT HALL COURT, ELLICOTT CITY, MD 21042 JOAN BURDETTE/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH EL MEMORIAL PK 10/14/2012 RANDALLSTOWN, MD 21. Signature of Funeral See 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical o (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page death? 1 Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 1 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury accurred injury work?
1 \(\sum \) Yes 2 \(\sum \) No Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined_ City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only o 29b. Sig ature and title 29d. Date signed (Month, Day, Year 30. Name erson who completed cause of death (Item 23a) (Type, Print V-Jau 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 09Day Physician/ 1^{Month} 2 0°T2 12:45PM Edna L. Gaines Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore Manor Care 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Virginia 1 □ M 2X F 0942341943 69 212-42-5792 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location filed within 72 hours after death with the Maryland at Director ms 23a or 28a-f s must be notified 1 X Yes 2 No MD N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. Funeral 21215 2553 W. Coldspring Ln. ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black "natural" 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the Steel Worker Factory 12th Grade permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, it Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary E. Daniels James Lee Tune 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 2553 W. Coldspring Ln., Nakia Ruffin(Granddaughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory/0//3//3 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 276 Sepher Brown Jr. Funeral Home PA 21217 MD2140 N. Fulton Ave., Baltimore, ienich 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARGNOMA Ph, i ian/ METASTATIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Disk to for as a consequence of thany, leading to immedicause. Enter Underlying Cause (Disease or iinjury death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Box 68760 9 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day 5 Other (specify) Pregnant at time of death ed by the a g Unknown P.O. signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Division of Vital examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Certificate: 27, Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D DU059107 0-10-2012 REISTERSTOWN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRINGS INC. 210 BUSINESS CENTER DRIVE MD 21136

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

16

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Deat Month Day 554M Physician/ Medical 4c. County of Death 4b Examiner 9. Birthplace (State or Foreign 8. Date of Birth If Und If Under 24 Hrs **Funeral** Days (Month, Day, Months Min Mary Land 1 ★ M 2 □ F 1942 Director 220-42-6325 69 Nov Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ₹ Yes 2 □ No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 1211 W. North Avenue 21217 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. . Was Decedent Ever in U.S. Armed Forces? 1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 K Never Married 2 ☐ Married by Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify Specify: black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education unk (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) social security adm 0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Dorothy Cooper Samuel Garrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 124 W. Franklin Street #515 Baltimore, MD Jones Garrett-McWebb/sister 21201 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signature | Funeral Sedice Licens 22. Name and Address of Facility Vade Board 655 W. Baltimore Street STate Anatomy 23a. Pat 1. Enter the disease, or complications that because shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a con equence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to to, as a consequents The law requires that the death certificate be executed Cause (Disease or linjury and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) ∟ Pregnaπ □ Unknown Yes 2 No been signed by the a should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed has page 2 s 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital or Attending Physician: director. Be Hospital 2 1 🗌 Yes ursing Home 5 Residence 6 Other (Specify) ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral Manner of Deg 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: injury Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Output Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29c, License number 29d. Date signed (Month, Day, Year, 29b. Signature an of certifi 0 who completed cause of death (Item 23a) (Type, Print) ss of perso 30. Name and add Day, Year) 1 6 2012 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

12-07559 Nick G. Gartelman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ick G. Gartelm	1- For State Certificate of Death									2 3307		
Physici	an/	Registrar 1. Decedent's Name (First, Middl	e,Last) Nick Gi				-	2	. Date of Deat	g. No. h		3. Time of Death
ledical Exami		Nick-	G	LDCI C			an Sr	-	Month October 5,	Day 2012	Year	2159 hrs
1 /		4a. Facility Name (if not institution	n, give street and number)		4b. C	ity, Town, or	Location of				county of Death	
		Harbor Hospital				altimore						
Funeral Director		5. Social Security Number 213–84–6694		e (In yrs. last		Under 1 Year Ionths Day		24Hrs. Min.		•		hplace (State or
Director			1 X M 2 F	50	Yrs.	loritins Day	Hours	IVIII t.	July	29 1	962 Col	Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c City To	wn or Location							10d. Inside City Limits
			3	**	oklyn Pa	ark						1 Yes 2 X No
Aaryland 28a-f show	cto	Maryland Anne 10e. Street and Number	Arundel	PLO		. Zip Code			10	a Citize	n of What Coun	
or 28	Director	6013 Ritchie H	IATNY .		10.	. Lip oodo			, i	y. Citizei	USA	u y ?
with the s 23s c noti	g	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was De	cedent of His	spanic Origin	n? (Spec	ify Yes or No-	1/4		can Indian, Black,
leath ritem	Funer	1 Never Married 2 Ma	Armed Forces?	X No			n, Mexican, F				White, etc.	Arrivator, Diagr.,
after c	by F	3 Widowed 4 X Div	orced If Yes, Give Year or Dates:	[2 <u>1</u>] 140	1 Yes	2 🔀 No	specify:			Sp	_{pecify:} whit	ce
nours		15. Decedent's Education (Spec	cify only highest grade com	pleted) 16	a. Decedent's Us during most of	sual Occupa	tion (Give kir	nd of wor	k done	16b. Kin	d of Business/Ir	ndustry
136 hin 72 } e. than "1	olet	Elementary/Secondary (0-12)	College (1-4 or 5	·	_	_	. 50 1101 0.	36 1611160	,		_	
15-0036 filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Completed	12th 17. Father's Name (First, Middle,	1 act)		Tow True		40.14.0	N			Towing	
	Be C	• • • •	ŕ	man C	artelman		Dor:		irst, Middle, M	laiden Su V[zier zer
MD 21215-0036 2 should be filed within 7 h and Mental Hygiene. 27 is marked other than matic event, the Medica	To B	Gilbert J 19a. Informant's Name/Relations!			19b. Mailing Add					_	or Town, State.	Zip Code)
		Nick G Gartelm	an Jr son	1	7510 Ro							
		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 10 Pate 12 20c. Location - City or Town,										
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		1 Burial 2 Cremation 4 Donation 5 Other Sp	3 Removal from Sta	Gle	en Haven	Cemet	ery -	10/1	0/15/1	2 -Gl	en Burn	ie Maryland
Baltimo permit. Page Department Important: injury or ot		21. Signatu of Funeral Service	Lio habo		22. Name	and Address	of Facility	C+al	linge	Fine	ral Hom	e P.A.
E F P B		12	8-K1			3111	Moun	tain	Poad	Daga	dena MD	
Physician		23a. Part I. Enter the dia ase, or failure. List only one puse	complication that caused on each line Sudde	the death. Do	not enter the mo	ode of dying,	such as card	diac or re	spiratory arre	st, shock	or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Ather	rosclei	cotic ca							Death
A A		or condition resulting in death)	Due to (or as a conse		-1 41							
	ē	Sequentially list conditions, if any, leading to immediate	b. Stress of Due to (or as a conse		ar Arte	rcatio	on				-	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c									
ecuted and transit		events resulting in death) Last	Due to (or as a conse	quence of):							6	
	dical	X UNPENDED		23a-b	27,28a-	f.per	me. 29	35 1	-17-13	Sm		
ox 68760, and certificate be ex attending physician for use as the burial	Med	IF FEMALE:	23c. If yes, outcom			<u>2935</u>	1-23-	-13 v	rt	_	ate of delivery	
6876(certificate nding physe as as the b	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal de	ath 3 [Ectopic p	regnancy	,		onth Da	ay Year
	sic	1 Yes 2 No 9 Unk	nown 9 Unknown	time of death	5 Other (Specify)						
· 4 >4	된	Part II. Other significant condition		but not result	ting in the underl	ving cause o	iven in Part	1	23e. Did tob	acco use	contribute to the	ne cause of death?
P.C	ğ		-						_			ibly 4 🗸 Unknown
ds, equin	Completed			-				- 5	24a. Was a	n I	24b. Were auto	opsy findings available
COT s law 1 e 2 sh	ם			_					autops perforn		prior to co death?	mpletion of cause of
Re iificate	ပိ	25. Was case referred to medical	·			20 Place	of Dooth (CI	h t t	1 ✓ Yes 2	∐ No	1 Yes	2 No
/ita	B	examiner?	Hospital: 1 Inpatier	nt 2 🗸 FR/	Outpatient 3		of Death (Cl			Residence	e 6 Other:	
Division of Vital Records, tal or Attending Physician: The law requirers after death. In Director: After this certificate has been sited in by the funeral director, page 2 should the contractions of the funeral director.	٦.	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	v 28t	. Time of Injury		y at Work?		d. Describe ho			
on ath.	틶	1 Natural 5 Pendi		· I	d 2100 hr	را ا ا ا	es 2 🗶 N	o su	ıbject	assa	ulted	
/iSi r Att ter de virecte n by t	fica		19ation 28e Place of Ini				uilding, etc.	28				al Route Number, City
Dital o	Certification:	Suicide 6 Could not be determined (Specify) Residence Specify Residence Could not be determined Could not be dete										hie Hgwy.
the Hosp hin 24 ho the Fune	<u>ह</u>		ysician: To the best of my					e, and due	e to the cause	(s) and m	nanner as stated	
Division of Vital Rec To the Hospital or Attending Physician: The L within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	2	niner: On the basis of exam and manner stated.	nination and/o	r investigation, ir	my opinion,	, death occur	rred at th	e time, date a	nd place,	and due to the	cause(s)
	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										h, Day, Year)	
		Mar		Z>'	n (1)	O.C.N	VI.E.			Octobe	er 6, 2012	
1		30. Name and address of person v Russell Alexander MD.			•	O altina a a-	Ctract D	altiv- a	- MD 040	22		
-U /	ate	31. Date filed (Month, Day, Year)	Assistant Medica		я 900 VV . Е	pailimore	ગાલ્લા, Ba	aitimore	e, MD 212	∠3		
- 31	-154	(monus, vay, real)	Joz. Rogistiai	- a.a.a.m.								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Goetz October 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1304 Willow Road Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year, 219-30-5292 **Director** 1 □ M 2 🗚 77 June 16,1935 Maryland Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Dundalk 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Willow Road items 23a Funeral 21222 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 6 ò 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Court Reporting Page 1 and 2 should be filed within 73 nent of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) 12 years College (1-4 or 5+) Service Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Edward Goetz Pearl Daisy Riley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Suit 1319 Willow Road, Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Meadowridge 12, 2012 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility.
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease or complications that caused the death shock, or heart failure. List only one cause or each 23a. Part 1. Enter the diseas pt enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final Physician/ CHRONIC 4MPHOCYTIC LEUKEMIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ BRONCHIECTESIS Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No ၉ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1. **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day. Year) D46071 MA SM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY CARE EDMONSON 4538 EDMONDSON AVE ESEG

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecedent's Name (Eirst, Middle, Last) 2. Date of Death Physician/ 16-38 M Stober 2012 Medical Facility Name (if not institution, give street and number) 4c. County of Death 40 City, Town, or Location of Death **Examiner** () 8 Date of Birth 9. Birthplace (State or Foreign Security Number 7. Age (In yrs. las birthday) **Funeral** 215-13-8858 **Director** 1 **X**M 2 □ F 28 1984 Maryland Usual Residence of Decedent 21. 28a-f show 10c. City, Town or Location at 10a. State 10b. County 10d. Inside City Limits with the Maryland Director must be notified 1 Yes 2 No Maryland Harford Havre de Grace 10e. Street and Numbe 10f. Zip Code o 10g. Citizen of What Country? 23a 3745 Harmony Church Road 21078 USA items death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black White etc. o þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify. "natural" 3 Widowed 4 Divorced Completed White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Heating & than Elementary/Secondary (0-12) College (1-4 or 5+) Air Conditioning Co. the Repairman other Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည Calvin Elmer Gibbs Carol Marie Niswonger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Carol M. Gibbs / Mother P.O. Box 366, Darlington, Maryland 21034 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem cemetery, crematory or other place) State injury or al fron Department Important: Darlington Cemetery 10-19-2012 Darlington, Maryland Donation 5 DO her (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. any 1317 Cokesbury Road, Abingdon, Maryland 21009 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the Onset and Death Immediate Cause (Final ystic Ph_sician/ Torosis disease or condition Medical Examiner resulting in death) Due t (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last ding physician Physician/Medical death certificate be P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be d by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed Division of Vital 25. Was case referred to medical or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural A hours after death.

n 24 hours after death.

ne Funeral Director: After a in by the funeral or and in by the funeral funeral in by the funeral funer 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) who, completed cause of death (Item 23a) (Type, Print) 30. Name and address of Hos Orleans Street. Fathmore ma 2128 Hug

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Physician/ Arthur Howel 10:32 PM 7012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mercy Medical anter Ralfmore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Morth, Day, Social Security Number 6. Sex Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Carolina .64.85 Yrs **Director** North Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 1Qa. State 10c. City, Town or Location Director 1 Tes 2 No MOY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2621 Llewelyn Ave. Funeral trenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Specify: Bla Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ HAWO 19a. Informant's Name/Relationship (Type, Print) | W ite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 amona tower 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Date Page 1 8/12 4 ☐ Donation 5 ☐ Other (Specify) rematon 10 22 Name and Address Facility SS 2222 W. North A 21. Sign of Funeral Service Licensee Funeval Home, P.A. 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Electrolyte Physician/ abnormali disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and the detached for use as the burial-transit trok that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death □ Pregnanτ :
 □ Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tract 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 1 Yes 2 No certificate Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of filled in by the funeral Certificate: 28c. Injury at 28d Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural iniurv work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 2012 78095033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place, Baltimore, ST. Paul Hostetter 345 MD ason 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Bernard W. Hammaker 4b. Gity, Town, or Location of Death Eacility Name (If not institution, give street and number) 9. Birthplace Country) 5. Social Security Number 8. Date of Birth (Month, Day, Sex 1M 2□ F 7. Age (In yrs. last birthaav. Hours Months Davs 217-10-3271 95 1917 May 1 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐Yes 2√☐No MD. Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1158 Luther Drive 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Black White etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐Yes 2X No Specify. 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Dept of the Army <u>hospital management</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Hammaker Mary Boteler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13205 Sleep Creek Lane Smithsburg, MD Mary Bausman/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc, or heart failure. List only one cause on each line. Immediate Cause (Final 4-2018 oulen disease or condition resulting in death) Due to (s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? n Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 242 No ☐Yes 2 No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

2

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, It. My diesi Ern in terminal by putfind a once.

Baltimore, Maryland 21215-003

death with the Maryland

e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Et hours after death.
E Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Examine Physician/Medical ģ Be Completed Medical Certification: To

9 Unknown
s contributing to death but not resulting in the underlying cause given

25. Was case referred to medical		26. Place of Death (Ch
examiner?	Literation in the land	244

1 ☐ Inpatient 2 ☐ ER/Outpatient

		26.	Place of Dea	th (C)	neck only one)					
3 🗆 DOA		Other: 4	Nursing H	ome	5 Residence	6 ☐Other (Specify)				
	28c.	Injury at Work?		28d.	Describe how inju	ury occurred				

27. Manner of Death 1 Matural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time Injury
3 ☐ Suicide	6 Could not be determined	28e. Place of Injury - At h	ome, farm,

street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)

15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one)	and manner stated
29b. Signature and title of certifier	

2.₽No

1 ☐ Yes

29a, Certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

null St. Hogstein MAZI740 win

State Registrar

within 24 hor To the Fune completely fi

Please Type or Print in Black Indelible Ink, Fnsure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene 12-07589 James D. Holdclaw 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month Day October 6, 2012 Year Holdclaw **Medical Examiner** D. James 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Saint Agnes Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Foreign Country) Months Days Hours Min. Director 70 215-40-8307 1 M 2 F 42 04 17 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State any 1 X Yes 2 No Baltimore permit. Pages 1 and 2 shoule be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other traumatic event, the Medical Examiner must be notified at once. NA MD irector 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21216 29 Piggs

Physician /Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Ω	2/29 Kiggs Ave										
Be Completed by Funeral D	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces?			nic Origin? (Specify exican, Puerto Rican		14. Race - Americ White, etc.				
/ Fu	3 Widowed 4 Divorce	1 Yes 2 X No	1 Y	es 2X No s	pecify:		Specify: Blac	ck			
q p	15. Decedent's Education (Specify of	only highest grade completed)			(Give kind of work do NOT use retired)	one 16b.	Kind of Business/In	dustry			
ete	Elementary/Secondary (0-12)	College (1-4 or 5+)		abled	J 1401 use remou		Disabl	Led			
Ē	8th grade	na	D15			Add to Add to	- 0				
ပိ	17. Father's Name (First, Middle, Las				Mother's Name (First izabeth						
œ.	Chester C. Hol		19h Mailing A	ŀ	nd Number or Rural F			Zin Code)			
ပ	19a. Informant's Name/Relationship (Holtzo	Taw Sister	2729 R	iggs, F	Baltimore	e, Md	21216				
4	20a. Method of Disposition 1 Burial 2 K Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) On-Site 20c. Location - City or T crematory or other place)										
	4 Donation 5 Other Specifical Six nature of Funeral Service Lice	y:									
	2. Signature of Furieral Service acc	K. L.	Marc	ne and Address of h F H H) Wabash	n Ave, B	altimo	re, Md	21215			
-	23a. Part I. Enje the disease, or com	plications that caused the death	. Do not enter the	mode of dying, suc	ch as cardiac or respi	ratory arrest, sh	nock, or heart	Approximate Interval			
	failure. List only one cause on e	each line. . Atherosclerotic Cardiov						Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence o									
	Sequentially list conditions,	J									
ner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence o	f):								
Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):								
		f									
lica	UNPENDED	AMENDED									
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg		- 🗆		2:	3d. Date of delivery	av Year			
ian	past 12 months?	1 Live birth 4 Pregnant at time of de		death 3 [_]	Ectopic pregnancy		Month D	ay Year			
ysic	1 Yes 2 No 9 Unknow		o [_] Other	(Opoury)							
/ Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the und	lerlying cause give	en in Part I.		o use contribute to t				
Ď.	Diabetes Mellitus							ably 4 ✓ Unknown			
lete						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of			
μĸ						performed? ✓ Yes 2		s 2 No			
Be C	25. Was case referred to medical				Death (Check only o	ne)					
To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient				dence 6 Other				
	27. Manner of Death 1 ✓ Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of Inju	1 _	_	Describe how in	njury occurred				
ation:	2 Accident Pending	ation	L	1 Yes	3 2 No	١					
	3 Suicide 6 Could no	ot be 28e. Place of Injury - At h	ome, farm, street,	factory, office build		Location (Street or Town, State)	and Number or Rui	ral Route Number, City			
Cer	4 Homicide determin	(4,7,1,0)									
cal	(O) (Controllar)	clan: To the best of my knowled	lge, death occurre apd/or investigation	d at the time, date n, in my opinion, d	and place, and due t eath occurred at the t	o the cause(s) a time, date and p	and manner as state place, and due to the	ed. e cause(s)			
Medi	Suicide 6 Could not be determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. October 12, 2012										
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	11/1/1	a completed south and death (lies	232)	-10-							
	30. Na, e and address of person who Russell Alexander MD.	Assistant Medical Exar	piner 900 W	/. Baltimore S	treet, Baltimore,	MD 21223					
tate	24 0-6 0-00 -0 -0 -0 00	Decide 32 Register's Signature	and the second								
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		1	For State Registrar		State of Ivi	arylariu /		ificate of L		and iv	icitairiy	Reg. No	20	12	330	84
	Physicia	_	1. Decedent's Name	(First, Middle, Last)	, /						2. Date of De	eath Da	ay	Year 012	3. Time of De	
1	Medic	al	Vera 4a. Facility Name (if I	w. 17 a	reet and number)		Т	4b City, Town, 9	r Location	of Death	10	40	c. County of		4:20	AM
	Examin	er	Union	Memo	. /			1/ /	mor	<u></u>						
	Funeral Director		5. Social Security Nu 215-22-7	mber 6. Sex		e (In yrs. last b		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Date)	ay, Year)	6	9. Birth Cour	place (State or Fo	oreign
	show dat	or	Usual Residence of 10a. State	10b. County		10c. City, To	wn or Loc	ation							10d. Inside City L	imits
	Maryl, 28a-f ottfiec	irect	MD	Baltim	are	Gwy	Inn	DaK				,			1 🗌 Yes 2	No
	vith the Maryland 23a or 28a-f sho st be notified at	Funeral Director	10e. Street and Num	om ofice	6/ Rac	d		10f. Zip Code	212	07		10g. C	itizen of W		ntry?	
	death v	Fune	11. Marital Status	amp He	12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cubi			cify Yes or No- Rican, etc.)	-		- Ameri	can Indian,	
900	2 hours after death v "natural", or items idical Examiner mu	ted by	1 Never Marrie	/	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.	No		☐ Yes 2 ☑ No					Specify:	13/	icK	
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Maryland 2	should be filed within 7 and Mental Hygiene. is marked other than aumatic event, the Me	To Be	17. Father's Name (F	irst, Middle, Last)	Je/ch			,,,,,,	18. Moth	her's Name	First, Middle	, Maiden	Surname) Bro	wn		
/ary	should n and M r is mar raumat		19a. Informant's Na	me/Relationship (Typ	t, Print)	/ []	9b. Mailin	g Address (Street	//	per or Rura	I Route Numb	er, City o	r Town, St	ate, Zip		0
	and 2 s Health tem 27		Tatrice 20a, Method of Disp	osition	Dave ht	20b. Place	of Dispos	Sergen sition (Name of	[4p+.	7.1, 10 Date	20c. L	ocation -	City or 1	own, State	8
mo	Page 1 nent of ant: If it		1 ☑ Burial 2 ☐ 4 ☐ Donation	☐ Cremation 3 ☐ F 5 ☐ Other (Specify)	Removal from State	Ceyfie	but	etory or other pla ソン		10-	3-2012	B	a/ti	mo	re MD	
Baltimore,	permit. Page 1 and 2:3 Department of Health Important: If item 27 any injury or other tr		21. Signature of Fun	eral Service License	h		22.	Name and Addre	ess of Facil	ityVay	chn C=	Gre			ralserv	
	40 = 60		23a. Part 1. Enter	he disease, or compli	ications that cause	d the death. D	o not ente	r the mode of dyli	ng, such as	s cardiac o			7 // 51	DW	Approximate	
	Physician/		shock, or hear Immediate Cause (I disease or condition	t failure. List only one inal	e cause on each lin	е.		واوام							Onset and Dea	en ath 5
P	Medical Examiner		resulting in death)	C.	Due to (or as	a consequent	_								1	
(V		iner	Sequentially list cor if any, leading to im	mediate	Due to (or as	a consequenc	e of):									
	executed an and rial-transi	Examiner	Cause (Disease or i that initiated events resulting in death) L	njury	Due to (or as	a consequence	ce of):									
0		1= 1	resulting in doubly b		d										<u> </u>	
68760	rtificate ing phy e as th	/Med	IF FEMALE:		3c. If yes, outcome	of programmy										- 47
Box (e death certifica the attending pl thed for use as t	Completed by Physician/Medica	23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?		2 Fetal de	eath 3	Ectopic pregnar Other (specify) _	ncy				23d. Dat Mor		very Day Yea	ır
P.0.	requires that the decensions signed by the second to be detached	oy Ph	Part II. Other signif	cant conditions cor	ntributing to death	but not resulting	ng in the u	nderlying cause g	iven in Par	t I.	23e. Did		/		the cause of deat	
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Records,	The law re ate has be page 2 sh	mple									per	opsy formed?/	, d	rior to c eath?	opsy findings ava ompletion of caus	se of
a B	ician: The certificate rector, pag	Be Co	25. Was case referre	ed to medical				26. F	Place of De	eath (Chec	1 🗌 Yes k only one)	2 141	No 1	☐ Yes	2 No	
VII.	Physician: this certific al director,	은	examiner? 1 Yes 2	No		tient 2 ER		t 3 🗆 DOA			ome 5 Res				fy)	
n of	iding Ph th. After th funeral	cate:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigation	28a. Date of inj (Month, Da		b. Time of injury	28c. Inju woi M 1 [iry at rk? ∐Yes 2.[28d. Describe	how inju	ary occurre	d		
Division of Vital	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the but	Certificate:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	jury - At home tc. (Specify)	, farm, stre	eet, factory, office			28f. Location City or To	(Street a own, Stat	nd Numbe e)	r or Rur	al Route Number,	
_	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check 2	Certifying Physi Medical Examin Certifying Nurse	er: On the basis of	examination an	id/or invest	igation, in my opin	ion, death	occurred a	t the time, date	and plac	e, and due	to the c	ause(s) and manne	er stated.
	vithin Yo the comp	2	29b. Signature and		ALA.	771	1.0	29c. Licens							, Day, Year)	
	(5)		20 Name and add	ess of person who co	mpleted cause of	death (Item 22	a) (Type 5	24	389	146		10	110	6/	x012	
			Gabriel	a Mola	na HI) 20	310		pver	sty	Parku	zy	Bal	2mc	re, MD2	1818
	Sta		31. Date filed (Mont	n, Day, Year)	2017 32. Regist	rar's Signature	4	bro that		•		•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND OI LINE A-Brate of Maryland Department of Health and Mental Hygiene 33085 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Physician/ Month 1105 Mabel E. Harrison 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death Examiner imore 3 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Director 219-12-2064 1 M 2 X F 88 11/13/1923 PA Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland Director XX Yes 2 No MD n/a Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21228 5540 Frederick Ave. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Force Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 1 ☐ Yes 2X No Specify. I Hygiene. other than "natural", If Yes. Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Circular Advertising Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of ၉ Hester Hornbaker Elwood Barnhart permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 428 Pine Terrace, Glen Burnie, MD 21061 Kevin Harrison/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Panation 5 ☐ Other (Specify) Mt. Olive Cemetery 10/5/2012 Mt. Airy, MD 21. Sign atur of Funeral Service Ligensee 22 Name and Address of Facility Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 Part 1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoo, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 5 – / DAYS ediate Cause (Final Physician/ C. DIFF. COLITIS di lease r condition re ultino in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA 5-7 DAYS Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Exami death certificate be executed burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Hospital or Attending Physician: The law requires that the c 24 hours after death.
 Funeral Director. After this certificate has been signed by th Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Harrison, Mabe 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 N 1 ☐ Yes 2 📉 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 🗌 No Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practificaer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 726428 9/30/2012 A. Abdelaziz, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. Gaton Aue Baltimore, MD 21229 900 Ahmed Abdelaziz 31. Date filed (Month, Day; Year) 32. R istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mooth 9 2012 11:38A M Hartzell Hattie Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BAltimore Examiner 4b. City, Town, or Location of Death Baltimore 3111 Aspen Ct. 8. Date of Birth (Month, Day, Year)
Dec. 26, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 218-30-2015 1 M 2 X F 79 1932 Maryland Heath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. Count 10d. Inside City Limits 10c. City, Town or Location BAltimore Director Baltimore Maryland 1 ☐ Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21227 3111 Aspen Court USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Household Homemaker 10th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill I Health end Mental ည Breen Henrietta Herman Unsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 Holmespun Dr. Pasadena MD 21122 Agnes Mullins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Depertment of Importent: If any Injury or 10/12/12 Baltimore MD Loudon Park Cemetery 21. Signat in of Funeral Service License Stallings Funeral Home P.A. Road Pasadena Md 21122 Mountain 23a. Part 1. Enter the disc or complications ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure ist only one caus Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Cawcer omouths Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physiclan: The law within 24 hours after death.
To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2 completely filled in by the funeral director, page 2. autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature apd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 30. Name and ad who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Dav. Year) 32. Registrar's Signature 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 10. 2012 HAUCA 7:08 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1terITAGE MADONNA Jarrettsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours Country)
DE 220-20-1673 **Director** 1 □ M 2 **X**XF December 17,1925 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Timonium 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 652 Oak Farm Ct U.S.A. 21093 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 N No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 XX Married δ Maryland 21215-0036 1 ☐ Yes 2 WNo Specify: White Specify: 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Homemaker Own Home t. Page 1 and 2 should be filed with the property of Health and Mental Hygien rent: If item 27 is marked other 1 jury or other treumatic event, the streumatic event, the property of the property is the property of the prop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Claude Maine Adams Hattie Mateer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Haugh (Husband) 652 Oak Farm Court Timonium, MD 21093 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it any Injury or or 1 XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park Cemetery 10/13/12 Baltimore, MD 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc. . Signature of Fugieral Service Licenses 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ drahon deyo disease or condition Medical resulting in death) Due to (or a va consequence of) Examiner months phyla Sequentially list conditions, Examine if any, leading to immediate cause Enter Underlying Cause (Disease or injury Due to (or as a consequence of): sician and burial-transit or Attending Physicien: The law requires that the death certificate be executed Glas that initiated events Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPO 1 Yes 2 No 3 Probably 4 1 Onknown Dissetes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate ASCUPECAD Yes 2 1 10 24 hours after death.

Funerel Director: After this certifice etely filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Assisted LIVIA 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State the Hospitel Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Funer completely fi 29a. Certifier 2 Getting righting the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1731295 10/11/12 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltomare Kenwood Ave 21206 mo 5741 wesz 31. Date filed (Month Day, Year) -

OHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Topic of Learning Colored Colo	y M Hebron	State of Maryland / Department of 1-For State Certificate of Registrar	Death	. 2012 3308							
As Fazilin Name of order institutions, give stood and number of control processor (pages) Children Childr	Physician/ lical Examiner	Decedent's Name (First, Middle,Last)									
Symbol S		, , , , , , , , , , , , , , , , , , , ,	b. City, Town, or Location of Death	4c. County of Death							
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MD Prince George S Clinton			nc	10d. Inside City Limits							
Months State Months Mont	Maryland 28a-f show d at once.		10f. Zip Code 10g. C								
20c Location - City or Town State 20c Location - City or Town	ath with the litems 23a or litems 23a or litems 13a or litems litems 13a or litems 13a or litems 15a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Yes	s Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian, Black,							
20c Method of Disposition Color from State Community of the Park Com	ours after de satural", or saminer mi	3 Widowed 4 Divorced If Yes, Give Year or Dates:	3 Widowed 4 Divorced If Yes, Give Year 1 Yes, 2 No specify: Specify: B 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done 16b. Kind of Busines								
20c Location - City or Town State 20c Location - City or Town	within 72 h giene. her than "n Medical E	Elementary/Secondary (0-12) College (1-4 or 5+) 12th Unemp1	oyed								
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23. Part I. Either the diseases for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each file. 23. Part I. Either the diseases for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each file. 23. Part I. Either the diseases for complications are diseased for complication and the cause of each file. The cause of the cause	rmit. Pages spartment of aportant: I jury or oth	4 Donation 5 Other Specify: Washington									
If any, leading to immediate cause. Enter funderlying cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death) Last considering cause (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death cause (Disease or injury that initiated events resulting in death (Day Near Last cause) (Disease or injury that initiated events resulting in death (Day Near Last cause) (Day Near Last cause) (Day Day Near Last cause) (Day Day Day Day Day Day Day Day Day D	hysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease a. Chronic Alcohol Abuse)	e mode of dying, such as cardiac or respiratory arrest, s	shock, or heart Approximate Interval Between Onset and							
Section Sect	9	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
The MALE: 2	be execute ician and urial - tran	d. MENDED 23a,27,per me,									
The part is sufficient to the part is the	certificat nding ph se as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of death 5 ☐ Ot 9 ☐ Unknown	tal death 3 Ectopic pregnancy								
25. Was case referred to medical examiner? 1	that the the greed by detacl		naony mg oadoo garon mr ant m								
25. Was case referred to medical examiner? 1	The law requirate has been stage 2 should the		autopsy performed	prior to completion of cause of death?							
29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 2, 2012 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	Physician: er this certifi ral director, To Be	25. Was case referred to medical examiner? 1 Yes 2 No 28 Date of Injury 28b. Time of 1	3 DOA Other Nursing Home 5 Res								
Proceedings of the cause of the	ital or Attendi us after death. ral Director: lled in by the fi	Natural 5 Pending 1 Accident Investigation 2 Suicide 6 Could not be determined (Specify) Natural 5 Pending 1 28e. Place of Injury - At home, farm, streed (Specify)	et, factory, office building, etc. 28f. Location (Stree								
296. Signature and title of certifier O.C.M.E. October 2, 2012 30. Name (and addréss of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	5 - E >	298. Certifier - 48 +	red at the time, date and place, and due to the cause(s) ion, in my opinion, death occurred at the time, date and	and manner as stated. place, and due to the cause(s)							
Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	N S S S	29b, Signature and title of certifler Permutation of certifler	100								
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	P	Pamela E. Southall, MD Assistant Medical Examiner 900		23							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8, per fh. g932 10-19-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of De 2. Date of Death Day Year Physician/ Month 11:45A. CONSTANCE ANNA HERGENROEDER ,2012 CTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTO. TOWSON GILCHRIST HOSPICE 8. Date of Birth (Month, Day, Year)1943 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 218-40-2471 1 □ M 2 🛣 F 68 Director $10 - 16 - \frac{2012}{}$ MARYLAND r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🕱 No MD BALTO. **PARKVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 2 TIPPERARY COURT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Year or Dates. Black, White, et 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e 1 and 2 should be filed within 72 in of Health and Mentel Hyglene. If item 27 is merked other than "re other traumetic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) LAW OFFICE BOOKKEEPER 12TH Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ ANGELINA MANGANO RICHARD PHILLIPS , SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4303 CONIFER COURT REBECCA HERGENROEDER DTR GLEN ARM, MD. 21057 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1: Department of I Important: If its any injury or of ōΞ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKVILLE, MD PARKWOOD_CEMETERY 10-15-2012 21. Signature of Funeral Service Licens 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME, INC. 9705 BELAIR ROAD NOTTINGHAM, MD. 21236 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Netas disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami igned by the ettending physician and be detached for use es the burlal-transit To the Hospitel or Attending Phyalcian: The law requires that the deeth certificate be executed within 24 hours efter death.

To the Funeral Director, After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Dertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 21400 St-#4105, Baltimore, MD 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar		Cert	rificate of D	eath	R	eg. No.	112	33090	
	Physiciar		Decedent's Name (First, Middle, Last)	нтте				2. Date of Deat Month OCTOBER		Year	3. Time of Death 07:00 A M	
-	Medica	al	LANDRUM DELANO 4a. Facility Name (if not institution, give street	HITE and number)		4b. City, Town, or I	Location of Death	OCTOBER	4c. County		07.00 A	
	Examine	er	Gilchrist Hospice			Towson			Ва	ltimo		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthpi Count		
	Director		Usual Residence of Decedent	^{2 □ F} 78	Yrs.			09/30/1	1934 VA			
1	show	ō	10a. State 10b. County	10c. City, 1	own or Loc				10d. Inside City Limits			
	Mary 28a-f otifle	irec	MD Baltimore		Kin	gsville 10f. Zip Code			10g. Citizen of	What Count	1 Yes 2 XNo	
;	3e or	Funeral Director	10e. Street and Number 6616 Mount Vista Ro	ad		21087			USA		.,,	
	ems 2	nue	11 Marital Status 12. V	Was Decedent Ever in U.S.	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spen	ecify Yes or No- Rican, etc.)		ace - American Indian, lack, White, etc.		
	permit. Page 1 and 2 should be filed within 72 hours after death with the marylating Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23e or 28a-f show any injury or other treumatic event, the M. dicel Examiner must be notified at once.	by	1 Never Married 2 Married 1	Armed Forces? I ☐ Yes 2 XX No f Yes, Give Year or Dates.		Yes 2XXNo			Specif	TTL: 4 a		
200-c	"natu	Completed	15. Decedent's Educati (Specify only highest grade co		(Give k	lent's Usual Occupa kind of work done d	ation Juring most of work	ing	16b. Kind of I	Business/Ind	iustry	
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2	lled w I Hygi other ent, I	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			ne)	Ì	
yland	id be f Menta arked atic ev	욘	Walter Hite				Emma	Hubbard		01-1- 7:- (20 of a)	
Mar	shou h and 7 is m treum		19a. Informant's Name/Relationship (Type, PLucy Hite (Spouse)	Print)	19b. Mailin	ng Address (Street a	and Number or Hur L sta Rd.	al Route Numbel Kingsvi .	ille, Ma	rylan	d 21087	
e,	and and the self the		20a. Method of Disposition		ce of Dispo			Date		Location - City or Town, State		
Ē	Page nent o ant: If iry or		1 ☐ Burial 25/CT Cremation 3 ☐ Rem 4 ☐ Doppation 5 ☐ Other (Specify)		antic	Cremator	rv 10/1	5/2012			ie, MD	
Baitimore,	emit. epartn nporta ny inju		21. Signature of Funeral Service Licensee		22	2. Name and Address	ss of Facility SC ir Road.	nimunek Notting	runera ham. MD	21	236	
_	<u></u>		23a. Part 1. Enter the disease, or complicati	ions that caused the death.							Approximate	
	as our		shock, or heart failure. List only one ca Immediate Cause (Final	Azute Stra						1,	Interval Between Onset and Death	
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	Examiner	<u>*</u>	Sequentially list conditions, b. =	Due to (or as a conseque	ance off.							
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	2100 OI).							
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1,60	ath certificate be executed attending physiclen and for use as the burlal-transit	Aedical	d .									
687	ertifica ding p	₹	IF FEMALE: 23b. Was decedent pregnant 23c.	. If yes, outcome of pregnan	ісу				23d. I	Date of deliv	/ery	
P.O. Box	death c he atten led for u	Completed by Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal 4 Pregnant at time of do 9 Unknown		Ctopic pregnand Other (specify)	cy		'	Month	Day Year	
o.	requires that the des been signed by the s should be detached	Phy	Part II. Other significant conditions contrib	buting to death but not resu	ulting in the	underlying cause gi	iven in Part I.	23e. Did t	obacco use co	ntribute to t	the cause of death?	
S, P	ires th signe	lg b						1 🗷	Yes 2□No	3 🗆 Pro	obably 4 🗆 Unknown	
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of <	Attending Physiclen: The law er death, ector: After this certificate has by the funeral director, page 2	te: To		28a. Date of injury (Month, Day, Year)	28b. Time of injury	of 28c. Inju wor	ryat k?		how injury occ			
ion	tendir death. tor: Af the fu	lifi Ei	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injury - At ho	me. farm. st		Yes 2 ☐ No	28f. Location	Street and Nur	nber or Run	al Route Number,	
So S									wn, State)			
_	To the Hospital or within 24 hours affe To the Funeral Direction Completely filled in	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best of my knowl On the basis of examination	and/or inve	etigation in my onic	non death occurred	ar the lime, date	and blace, and	dae to the o	addo(3) and mainer oracous	
	To the H within 24 To the F complete	¥ e	only one) 3 Certifying Nurse P 29b. Signature and title of certifier	Practitioner: To the best of n	ny knowledg	e, death occurred at 29c. Licen:	the time, date and	piace, and due to	the cause(s) ar 29d. Date sig	u mariner as	stated.	
•	F ₹ F 8		I An Re	a M	LD	000	70635	-	1011	3/12		
	10/		30. Name and address of person who com			Print)				din-	717.46	
	101		Laura Patel 67 31. Date filed (Month, Day, Year)				e 4102	bach	mure,	MI)	4 607	
	St Regist	ate trar	OCT 1 G 2012	32. Registrar's Signar	gark							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edgar Month Hamilton **Physician** 11:35 AM October 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Days 236-32-1623 November 22,1924 Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Baltimore Director Maryland Dundalk 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? ō 8113 Longpoint Road 21222 USA 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 XNo Specify: White 9 3 Widowed 4 Divorced Completed al Hygiene. I other than "natura vent, the Medical E 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 years Assembler General Motors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h William L. Hamilton Ida M. Sarver ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Mary Hockenbrock daughter 8117 Longpoint Road, Dundalk, Maryland 21222 permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other 1 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition OCtober 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Maryland Holly Hill Memorial 15, 2012 21. Signature of Funeral Service Licensi Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 omplications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or hly one cause on each line. shock, or heart failure. List Immediate Cause (Final Due to (or s a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Ent. It is represented by the conditions of Examine Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed burs after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 3 □ DOA 2 ER/Outpatient မ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury 1 Tes 2 🗌 No Accident | 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1487953865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Alexunder

OCT 1 6 2012

31. Date filed (Month, Day, Year)

parker

32. Registrar's Sjgnature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Ernest Roy Harding 4:16 PM OCTUBO Medical 200 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 465-38-0827 1XXM 2 □ F 81_{Yrs} Country) **Director** May 23, 1931 Lytle, Texas Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore City 1XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2500 Banger St. 21230 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces þ ty Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₺ Widowed 4 □ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ns any Injury or other traumatic event to once. (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4 or 5+) Machineist Pharmaceuticals Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Unk Harding Gilcrease 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Neyer-Gray / Daughter 2500 Banger St., Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) tlantic Crematory Unk Glen Burnie, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Arteriosklerotic Vascular Disco disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day ate has been signed by the a page 2 should be detached t Yes 2 No 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? pertension 24a. Was an After this certificate has performed? 1 ☐ Yes 2-1 No Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be **Division of Vital** 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No Hospital |₽ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) osed Iwand, MD 9 46505 October 5, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph CM 900 Caton Avenue. Baltimore, Maryland 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ 9.49 PM nneth Jackson OCTOBER Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner RALTIMORE HOSPITAL 25 SINA BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 054.50.440 Days (Month, Day, Year) Director 56 09 Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director Baltimore Kandallstown 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Papago 21133 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. Was Deceuent Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Black Specify: Completed 3 Divorced 4 Divorced JACKSON 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) University Elementary/Secondary (0-12) College (1-4 or 5+) Medical ustems Payroll Manager 12th grade Be 17. Father's Name (First, Middle, Last) WY 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Page 1 and 2 should be McBride 19a. Informant's Name/Relationship (Type, Print) (WIFE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette B. Jackson Court Kandallstown MD KENNETH Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 22 2012 Baltimore, MD 10 Cremation Center 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funera [Service 8728 Liberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY HAEMORRHAGE disease or condition resulting in death) Medical Due to (or as a consequence of): 1 mTH. Examiner STAGE IV MOM SMALL CELL Section fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami METASTASIS EXTENCIVE Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ate has been signed by the a page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISEASE COROMARY CHRONIC KNONEY 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION, DIABRTES MELLITUS MSEASE autopsy performed' 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{Other (Specify)} ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NADLE MBBS RES - 000 OCTOBER 11 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAI 90 MACHIKET HOSPITAL BALTMORE APTE MBBS 31. Date filed (Month, Day, Year) 0CT 1 6 2012 32. Registrar's Signatur State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 9 pay 2012 eau 12:15 PM Kenneth W. Jefferies Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Johnson Hotel Pikesville Baltimore Social Security Number If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Davs Hours (Month, Day, Year) Director 217-52-3977 1x M 2 - F 61 195 Maryland March 31, Usual Residence of Decedent 28a-f show must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2K No MD Baltimore Pikesville 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? Funeral items 23a USA death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? 1X Yes 2 No 1971-Black, White, etc. 0 þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 x No Specify. white Specify: "natural", Completed 3 Widowed 4 Divorced 1973 the Medical 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filled within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) unk unk injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 215 Milford Mill Rd; Baltimore, MD 21208 Officer Knubsen - Officer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🗷 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Ronald 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ honic Medical resulting in death) 3 Weeks Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death been signed by the a should be detached t 2 No Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
Funeral Director: After this certificate has b autopsy performed 2 🗆 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No completely filled in by the funeral director, Be 26, Place of Death (Check only one, Hospital ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27, Manner of Death 1 ☑ Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 10/12

Registrar

DHMH 17 Rev 06-2011

State

10

M. Green St.

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Jascia

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/10/201 9:00 AM Sylvester R. Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4251 Nicholas Ave. N/A Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Director 217-14-3854 1 XM 2 D F 90 9/13/1922 MD Usual Residence of Decedent rai", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland rector 1 X Yes 2 No MD N/A Baltimore ö 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 4251 Nicholas 21206 USA Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Bace - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ò 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: Specify: Black "naturai", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) filed within 72 ial Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Balto. 12th Inspector City School permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: if item 27 is marked other any injury or other traumatic other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Philmore Jones Ella Bean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Sells-Daughter Apt.313 Balto. E. Madison St. MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 10/19/2012 OwingsMills, MD Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-East 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events truction Pulmonary disease aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No Dra 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier October 12, 2012 2164 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SAMBANDAN BASWAWW 3455 WILKEMS)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10/10/2012 Physician/ 11:29A M Anella Roma Johnson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Care Center Baltimore 5. Social Security Number Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min 089-62-9516 Director 1 M 2 X F 58 West Indies 2/12/1954 Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Directo Baltimore Baltimore MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 36-1 Rexmere Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married δ Maryland 21215-0036 within 72 hours after 1 ☐ Yes XX No Specify. Specify: black 3 Widowed 4 X Divorced Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene, dother than " Elementary/Secondary (0-12) College (1-4 or 5+) Medical Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) uld be file Mental F should be file h and Mental I 7 is marked o Kenneth A. Johnson Esmine A. Fullerton other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any Injury or other trau Wayne Shaw Dune Road Wayside NJ 07712 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Pinelawn parkorilal 10/22/12 Farmingdale NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHarman Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7221 Grayburn Dr Glen Burnie MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ TASTATI disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregpant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Dav 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Division of Vital director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP/C မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this funeral 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred To the Hospital or within 24 hours after death.

To the Funeral Director: After completely filled in by the fur 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year, State Registrar

Division of Vital Records, Hospital or Attending Physician: 24 hours after death within 24 hours a To the Funeral I

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Media

one)

Carol H. Allan, MD 31. Date filed (Month, Day, Year) State 6

29b. Signature and title of certifier

DP

Assistant Medical Examiner 900 W. Baltimpre Street, Baltimore, MD 21223 Registrar's Signafure

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arke

29a. Certifier (Check only)
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

October 13, 2012

Registrar

30. Name and address of person who completed cause of death (Item 23a)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33098 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Eddie Ellis Johnson 10:44 PM October 0 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min (Month, Day, Year) **Director** 262-55-5067 1**X** M 2 □ F 47 Dec. 23,1964 Florida Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location notified at Director 1 ☐ Yes 2X No MD Prince George's Capital Heights 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 809 Cedar Heights Dr. 20743 United States death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner rmed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: If Yes, Give Year or Dates "natural", **Black** 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Technician Cable Company d 2 should be filed with alth and Mental Hygien 27 is marked other t 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Gaddy Edythe Howe 11 Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau Robert Johnson / Brother <u>5940 Kimberly Ann Way, #304,</u> Alexandria, VA 22310 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 10/16/2012 Beltsville, MD 21. Signature of Funeral 30 M00382 22. Name and Address of Facility Rapp Funeral and Cremation Services 20910 933 Gist Ave. Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARRHYTHMIA Immediate Cause (Final CARDIAC Physician/ FATAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Directo for as a nonsequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami and trar Due to (or as a consequence of) resulting in death) Last buria attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performed? certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? within 24 hours after deaun.

To the Funeral Director: After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar e and address of person when

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mpleted cause of death (Item 23a) (Type, Print)

3001

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Oct 10, 2012 **Catherine Ann Jones** 3:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Gilchrist Hospice of Howard County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Months Days Hours Min Country) **Director** 219-70-2094 1 🗆 M 2 🕱 F 54 Nov 6, 1957 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9268 Broken Timber Way 21045 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Marine Mechanic Mechanics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Calvin Jones Sr. Patricia Ann Glass 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9268 Broken Timber Way Columbia, MD 21045 Christopher L. Jones brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct 11, 2012 Glen Burnie, MD Atlantic Crematory, LLC 4 ☐ Donation 5 ☐ Other (Specify) Sipparure of Fuheral Service Dicenses 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. In ter the dia ..., or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVARIAN Physician/ CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ng physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months?
1 Yes 2 No Month Year Day signed by the at d be detached for 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes **Division of Vital** 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Tes 2 X No မ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending Accident М 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: A completely filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and Mile of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DLUMBIA MD 21044

Registrar DHMH 17 Rev 06-2011

State

6336 CEDAR

32. Registrar's Signature

ABBAS MD

31. Date filed (Month, Day, Year)

LANE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33100 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Claudia Sharon Jarrell 11:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death rosedale paltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Social Security Number 1 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Country Hours Min. 1 🗆 M 2 🖰 F (MOBT)/87/1947 215-46-8127 65 **Director** Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 X Yes 2 □ No MD Baltimore Dundalk 10e Street and Number b 10f. Zip Code 10a, Citizen of What Country? items 23a or ner must be i Funeral 17 Portship Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or ite Black, White, etc. ģ 1 Never Married 2 X Married Jarrell, (1) Audia Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Office Manager Construction 77 is marked other traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dudley Deane Phyllis Faulkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Jonny Paul Jarrell / Husband 17 Portship Road, Dundalk, MD 21222 Department of Health Important: If item 2; any injury or other to once. other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Chesapeake Crematory 10/16/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Maryland Cremation Services, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Days to (or set a consequence of) flany, leading to immedia cause. Enter Underlying Physician/Medical Exam Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and does detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dea Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Year 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 X Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director. After this certificate has been signompletely filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: ٩ 1 Yes I XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical

Registrar DHMH 17 Rev 06-2011

State

29a. Certifier

(Check only one 29b. Signature and title of certifie

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

10

Baltimore MD

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OCTOBER. 2012 EDITH JUDELSON 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TUDOR HEIGHTS SENIOR LIVING BALTIMORE N/A Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) Director 027-18-5868 1 □ M 2 X F 89 08/27/1923 MA Usual Residence of Deceden and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7920 SUBET ROAD 21244 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SUBSTITUTE TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ **JACOB** TEMKIN LEAH PAVA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. LYNNE HAAS/DAUGHTER 7908 HUMBOLDT ROAD, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONGR. 10/15/2012 BALTIMORE, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ -ONG ESTIVE disease or condition resulting in death) Medical Due to (or as a nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown a | Haknowa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 No 1 🗌 Yes Division of Vital after death.

Director: After this certificd in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ٥ 1 🗌 Yes 2 2000 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Dooth Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the comple 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 2012 125039 rson who completed cause of death (Item 23a) (Type, Print) BALT. MA 2/109

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

201

2835

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

Lionel Keith	John	1	- For State	State of Mary	land / De	epartment of Certificate of	of Health a	and Mer	tal Hy	giene	gible		12	331
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Medical Exa	min		LIONEL	KEITH JO	HNSON					Month October 9		Year 2		of Death Ohrs
			ta. Facility Name (if not insti 4220 Towanda Ave	institution, give street and number) 4b. City, Town					, or Location of Death 4c. County of				th	
Funer	el	5	5. Social Security Number	6. Sex	7 Amp //-		Baltimore					N/A		
Direct		L	219-82-6417 Usual Residence of Deceder	1 X M 2 F	7. Age (in y	rs. last birthday) 49 Yr	If Under 1 \ Months E	ear If Under Pays Hours	er 24Hrs. Min.	8. Date of Bi		DD/YYYY) 9. B Forei	rthplace (S gnMAR) puntry)	tate or 'LAND
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a, or 28a-7 sho	To Be Completed by I			UIS C. JOHNSON mant's Name/Relationship (Type, Print) 19b. Mailing Address						ONG				
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Baltii permit. I Departm Importa		21	Donation 5 Other Signature of Juneral Servi	Specify: ce Licensee	K.	ING MEMOI			10-1		BAL	TIMORE,	MARY	LAND
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Physicia: /Medica		23	 Part I. Enter the disease, failure. List only one cause 	or complications that c se on each line.	used the dea	ath. Do not enter th	e mode of dying	g, such as car	rdiac or res	piratory arre	st, shoc	k, or heart		nate Interval
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fox 68760, leath certificate be executed attending physician and for use as the burial - transit	/Me		EMALE: . Was decedent pregnant in	the	outcome of pre	egnancy					23d.	Date of delivery		
Division of Vital Records, P.O. Box 68760. Hospital or Atteoding Physician: The law requires that the death certificate is 42 hours after death. 24 hours after death. Percental Director: After this certificate has been signed by the attending physely filled in by the funeral director, page 2 should be detached for use as the by	Physician/Me		past 12 months?	2 Fetal death 3 Ectopic pregnancy									зу	Year
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of Vital Records, P.O. og Physician: The law requires that it ther this certificate has been signed by meral director, page 2 should be detact	Peg								_ #	1 Yes	2 🔲 1	lo 3 Proba	bly 4 🗸	Unknown
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Vital Rec ysician: The list certificate director, page	a	25.	Was case referred to medic examiner?	Hospital:				of Death (C)	heck only o	ne)	!			
of V ing Phys After this	욘	27.	1 Yes 2 No Manner of Death	28a. Date o	patient 2	ER/Outpatient				ne 5 Re			Scene	
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Division tal or Atteodius after death. al Director: A led in by the fu	fica	3	Accident Inve	estigation 28e Place	of Injury - At h	nome, farm, street,				anatina (Ota				
Division: Bospital or Atteod 24 hours after death. Fuoeral Director:	Certification:	4 [ald not be (Specify)		, , , , , , , , , , , , , , , , , , , ,	idotory, omos p	allaling, etc.	201. L	or Town, Stat	eet and (e)	Number or Rura	I Route Nu	nber, City
E Hos 24 hc E Fuo etely f		(Che	Certifier 1 CertifyIng P	Physician: To the best	of my knowled	ge, death occurre	d at the time, da	ate and place.	and due to	the cause/s	s) and m	anner se etatod		
To the Ho within 24 F	Medical	one)	2 V Medical Exa	and manner sta	examination a	and/or investigation	n, in my opinion	, death occur	red at the ti	ime, date and	d place,	and due to the	cause(s)	
	2	29b.	Signature and title of certific	er			29c. License	number	·	2	9d. Date	e signed (Month	, Day, Year	,
		_/	Keodore Ill	King	JAV	m.D.	O.C.N	M.E.	OUNE		Octobe	er 10, 2012		
			Name and address of person The odore M. King, Jr.				O M/ D-11:		. 5					
S	ate		Date filed (Month, Day, Year)		istrar's Signati	Examiner 90	o vv. Baltim	ore Street	t, Baltime	ore, MD 2	1223			
Regis			OCT 1 5	2012 12		here								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 28 P Michael Joseph Kreft 5 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Rosedo oi. more Sex X 1 □ M 2 □ F Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/07/1959 Months Days Min. 218-70-9386 Director 52 show 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director 10d. Inside City Limits 28a-f MD 1 X Yes 2 □ No Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1908 Middleborough Road 21221 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Completed 3
Widowed 4 Divorced Specify. Year or Dates White other traumatic event, the Medical Decedent's Education. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Autobody Technician Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) KREFT Elmer Kreft Ora Bosse 19a. Informant's Name/Relationship (Type, Print) Department of Health and Important: If item 27 is many injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Kreft / Wife 1908 Middleborough Road, Baltimore, MD 21221 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Date 1 Burial 2 1 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/17/2012 Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 50 Onset and Death 515 disease or condition resulting in death) Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months? Pregnant at time of death Other (specify) Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examine?

1 ✓ Yes 2 ☐ No director, Be 26. Place of Death (Check only one) Other: မ 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manney of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred s after decal Director: Afte 1 Natural 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [the

State Registrar

V

29b. Signature and title of certifier

30. Name and address of persen who completed cause of death (Item 23a) (Type, Print)

HALL

29c. License number

74707

9000 FRANKLIN SQUARE DR. BALTIMORE, MD 21237

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Frances Krizan Medical 4a. Facility Name (if not institution, give street and number Examiner 4c. County of Death Icom ICO 18 If Under 240Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Pay Year) 9 1 🗆 M 2 💆 Country) Pennsylvania 178-30-0349 73 **Director** 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Wicomico Salisbury o 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral items 23a 326 Troopers Way 21804 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. o. þ 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", Completed 3 Widowed 4 Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse 12 Healthcare 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Krizan Theresa Paro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Theresa Scola / Sister 5709 Flager Drive, Cenreville, VA 20120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 🗆 Burial 2 🗴 Cremation 3 🗀 Removal from State any injury or 4 Donation 5 Other (Specify) Chesapeake Crematory 10/16/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury Examine Due to (or as a consequence of) burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a, Was an 24b. Were autopsy findings available page 2 s autopsy performed? Yes 2 Nc certificate has prior to completion of cause of death? ☐ Yes To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No P 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending Fafter death. 1 Matural 5 Pending work?
1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined building, etc. (Specify) the Hospital Medical 29a. Certifier 👱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentlying Name Frantitioner: To the best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 1 (Check within 2 To the I 29b. Signature 29c. License number

Registrar
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ime and address of person who completed cause of death (Item 23a) (Type, Print)

910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Koehler Norma 2:25 AM ID 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours November 19, 1941 Director 217-38-1670 1 □ M 2 🔀 F 70 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way lujury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Parkville Baltimore 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 Spindrift Court 21234 USA Apt C 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. Ş 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Real Estate Developer Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Kelly James West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 Robert Koehler Sr. Husband 11 Spindrift Court Apt C, Parkville, MD. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State Sacred Heart of Jesus Cem. Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 13, 2012 . Signature of Funeral Service Licensee 22. Name and Address of Facility. Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NELLMONIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospitel or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit YEARS END STAGE that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Year Pregnant at time of death Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LUNG TRANSPLANT, NON-ISCHEMIC CMP 1 Yes 2 No 3 Probably 4 Unknown CKD STG 3 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🔀 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{ Nursing Home } 5 \subseteq \text{Residence } 6 \subseteq \text{ Other (Specify)} ၉ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD RES 000 10-10-12 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of RAVEN BLVD., BALTIMORE, MD 21239 PANA LOCH 5601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH C932 10/23/2012 JH State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 MARIE 6: NA M LEWIS Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST BATIMORE HOSPICE TOWSON Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In vrs. last birthday) 8 Date of Birth Days Hours Min (Month, Day, 377-20-0863 Director 1 M 2 MF 85 Yrs 128/1927 MT Usual Residence of Decedent of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28e-f show other treumetic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County filed within 72 hours after death with the Meryland 10c. City, Town or Location 10d. Inside City Limits Director MD 1 XYes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral KENILWORTH AVENUE 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NY PUBLIC SCHOOLS TEACHER 12 permit. Page 1 end 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other treumestrant. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLIE SMITH CARSON Informant's Name/Relationship (Type, Print)
Archie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KENILWORTH HUSBAND AVE. BAUTIMORE, MO. 21212 HRCH+BALD EWIS 4611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 □ Cremation 3 □ Removal from State 10/24/2012 BALTIMORE, MD GARRISON FOREST 4 Donation 5 Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL 3CVS P.4. Signature of Funeral Service Licenses YORK ROAD. BAUTIMORE, MO. 21212 4905 01540 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) men 1cars Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the attending physician and the for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Month Pregnant at time of death 5 Other (specify) be detached 9 Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral Certificate: 27. Manner of Denth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending injury work?
1 Yes 2 No ☐ Accident Investigation 24 hours after deat Funerel Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Month, Day Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTO3CA 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5701 harle 31. Date filed (Month, Day, Year) State 32. Registrar's Signature 1 6 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month orman October 2012 3:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hookins timore (not al If Under 1 Year If Under 8. Date of Birth (Month, Day, Year) April 24, 1935 last birthday) Funeral 9. Birthplace (State or Foreign n yrs. **77** 213-32-9513 Hours **Director** 1**X** M 2 □ F MD 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director MD Baltimore Middle River 1 ☐ Yes 2 🛣 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1114 Seneca Road 23a 21220 permit. Page 1 and 2 should be filed within 72 hours after death with USA or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. "natural" Completed Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Warehouse Manager Elementary/Secondary (0-12) College (1-4 or 5+) 12th Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental H ဂ္ Albert V. Lacher Mary C. Wand and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1114 Seneca Road Baltimore MD 21220 Department of Health an Important: If item 27 is any injury or other trau Betty E. Lacher /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Holly Hill Cemetery 10/18/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 MAce Ave. Balto. ature of Funeral Service Licen Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ reprate disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine for as a consecutions of and that initiated events resulting in death) Last Due to (or as a consequence of) physician Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 2 No Accident Investigation Suicide Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifie 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

1800 Or Kans Street Baltimog, Md

MD

Sonta-Maria

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 748 per DVR G932 10/31/12 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10/12/2012 Physician/ 11:00 PM Elizabeth Mae Lippert Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Columbia Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1921 Director 214-12-1396 1 M 2 K F 91 Yrs. -89-05/11/2921 Maryland 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** MD Baltimore Catonsville 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 238 filed within 72 hours efter death with 715 Maiden Choice Lane, CC114 21228 **USA** 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 end 2 should be filed wit Department of Health end Mental Hygien Important: If item 27 is marked other theny Injury or other treumatic event, the once. Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Albert A. Daum Ida E. Mennerick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Webster Lippert, Jr. /Son 106 Wye View Rd., Queenstown, MD 21658 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 10/15/2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Hubbard Funeral Home, I 4107 Wilkens Ave., Baltimore, MD 21229 Daniel Simons 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY Physician/ PAILURE SECONDARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CARE ASSOCIATED HEALTH Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ettending physician end for use es the burial-transit or Attending Physicien: The lew requires thet the deeth certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year g Unknown g
Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š CHRONIC RENAL PAILURE Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No Yes 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 🗌 Yes |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aff 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title officertifier, 29c. License number 29d. Date signed (Month, Day, Year) Ø 13th 2012 D72139 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MD 21044 SYED Q. ABBAS MD 6336 CEDAR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 6 201 Registrar

HMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Seasons Hospice @ Northwest Hospital Randallstown Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days Hours Director 577-44-9031 1 □ M 2X F Aug 12, 1930 82 Pennsylvania Usual Residence of Decedent filed within 72 hours efter death with the Maryland in than "natural", or items 23a or 28e-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Pikesville 1 Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8909 Reisterstown Road 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) professor Howard University associate other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russelle Turner Lucien Diggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
177 Atlanta Avenue SE Atlanta, GA 30315 Jocelyn Lyles/daughter 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1
Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Since funeral Service 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Ronal d Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) GASTRIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit the Hospital or Attending Physician: The lew requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 4 Pregnant 9 Unknown 5 Other (specify) Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 🗌 Yes 2 № No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending Accident 1 Tes 2 🗌 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Quertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ≱itte 30. Name and address of person who completed cause of death (Item 23a) (Type, 69

State

Registrar

31. Date filed (Month, Day, Year)

6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 5 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Baltimore Genesis Perring Parkway If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Hours Months 1 □ M 2 🖫 F 240-12-6129 Yrs Director 90 North Carolina Mar 6, 1922 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1∏Yes 2∏No Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4819 Midline Road 21206 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ir than "natural", or 1 ☐ Yes 2 No Specify. Specify: white 3√ Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) waitress food industry 7 is marked other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jerry Ernest Mills Lizzy Brown Cruse ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important; If item 27 is any Injury or other trauonce. Dorothy Augustine/daughter 5514 Bucknell Road Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □Other (Specify) ng to no of Funeral Service Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ade, Firector 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cay on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical or as a consequence of) Examiner Securation list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Completed by Physician/Medical Exami within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran le to (or as a consequence P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. the

State Registrar

P

29b. Signature and title of certifier

Date filed (Month, Day, Year)

OCT 1 6 2012

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	_		State Registrar			Cer	tificate of l	Death		Reg. No. 2	012	33	Щ
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	Medic Examin		4a. Facility Name (if not institu	tion, give street and nu	mber)		4b. City, Town, o	r Location of Dea	1 Oct.	10 20 4c. County	12 of Death	11:40	A."
1			801 St. Anne Dri		Street			Harfo	rd Co	unty			
	Funeral Director		5. Social Security Number 220–36–1123 Usual Residence of Deceder	6. Sex 1 X M 2 □ F	7. Age (In yrs	3 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Min		th 3, 1939	9. Birthpl Co <i>unti</i> Mary .	ace (State or F Land	oreign
	land show dat	tor	10a. State 10b. Cou	nty		City, Town or Lo	cation				10	d. Inside City	
	e Mary r 28a-1 notifie	Director	Maryland Harf 10e. Street and Number	ord County	Sti	reet	Troi 7: 0 1					1 🗌 Yes 2	No No
	vith th	al [801 St. Ame Dri	Ve			10f. Zip Code 21154			10g. Citizen of United		-	
	death vitems	C	11. Marital Status	12, Was Dec	cedent Ever in t	U.S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No-	14. Rac	ce - America	n Indian,	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 🔀 I 3 ☐ Widowed 4 ☐ Divor	Married 1 X Yes If Yes, G Year or [2 No	9-	1 ☐ Yes 2 💢 No		ato mean, etc.,		ck, White, e White		
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6876	ertifical ding ph	/Med	IF FEMALE:	23c If yes o	utcome of preg	nancy				1	1		
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ou c	ittending death. stor: Afte y the fune	icate	1 Natural 5 Pe 2 Accident Inv	nding (Mo	nth, Day, Year)		worl	k? Yes 2 No	Zod. Describe	now injury occur	ied		:
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Certificate:			e of Injury - At ding, etc. (Spec		eet, factory, office		28f. Location City or To	Street and Numb wn, State)	er or Rural i	Route Number	ţ.
	spital hours a neral I		29a. Certifier 1 Certif	ying Physician: To the	best of my kno	owledge, death	occurred at the tim	e, date and place	e, and due to the o	ause(s) and man	ner as state	d.	
	To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check 2 ☐ Medic only one) 3 ☐ Certif	al Examiner: On the barring Nurse Practition	asis of examinat	tion and/or inves	tigation, in my opini	on, death occurre	ed at the time, date	and place, and du	ue to the cau	se(s) and manr	er stated.
	V with		29b. Signature and title of cer	entre de la constante de la co	N	10	29c. Licens	e number	27	29d. Date signe	ed (Month, I	ay, Year)	
7	WILL		30. Name and address of pers	son who completed car	use of death (Ite	em 23a) (Type, F	Print)	1020		10/	0		
{	(,)		H. Toppe 31. Date filed (Month Day, Yea	Kels	50C) Upp	er Ch	esapeo	rke DI	Bel	Uir	MDZ	1014
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr 2932 10-16-12 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NNEMARIE Month AUGUSTA LOHMANN 20 1.05AM Medical 10 Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOWARD COLUMBIA HUSP HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 577-52-1376 Days Hours 85 (Month, Day, Year) Nov 28, 1926 Director 1 🗆 M 2 💢 F Usual Residence of Decedent maru of Health and Mental Hygiene. Item 27 is marked other than "natura", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Columbia 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10617 Hickory Crest Place 21044 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Insurance be filed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernst Zehnter Marie Brinkmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau Wilhelm Lohmann 10617 Hickory Crest Place Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ₹ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Park Oct 19, 2012 4 Donation 5 Other (Specify) Clarksville, MD 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LOSTRIDI Physician, disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🕅 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 🗌 No 2 Accident Investigation 3
Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abul F. Arifuddowla 5755 Cedar Lane Columbia, Md. 21044 31. Date filed (Month, Day, Year) State 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year \mathbf{P}^{M} Andrea M. Luplow 10 Medical 201 2:00 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Dove House Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🗗 F Director 365-72-8669 55 01/14/1957 Unkn. th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location with the Maryland Director 1 X Yes 2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Washington Lane Apt. 1 21157 1 and 2 should be filed within 72 hours after death י of Health and Mental Hygiene. item 27 is marked other than אחסטייים אוויים יהייים 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mick Edwards Hnkn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Luplow / Husband 25 Washington Lane Apt. I, Westminster, MD 21157 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of P Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/13/2012 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause preach line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 💆 æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only or 29b. Signatu nd title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 10-12-1 30. Name and completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edith McMurray Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville The Village at Rockville If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Funeral July 22, Year) 913 Days Hours Pennsylvania 99 160-01-1969 1 □ M 2 🗓 F Director rel", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant If Item 27 is marked other than "naturel", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director 1 Yes 2X No Potomac Montgomery MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 20854 5 Over Ridge Court 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Pharmaceutical Executive Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mirian Edith Rea မ Joseph Henry McMurray 19b. Mailing Address, Street and Number or Rural Route Number City of Town, State, Zip Code)
5 Over Ridge Court Potomac, MD 20854 19a. Informant's Name/Relationship (Type, Print) Meg Shumaker/Niece permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 10/12/12 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Galling and the Screen Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the 1 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END Physician/ disease or condition resulting in death) STALLS DISHENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter the days. Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed ettending physicien and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? **Division of Vital** æ 26. Place of Death (Check only one) Other: 4/10 Nursing Home 5 - Residence 6 - Other (Specify) ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Acertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2012 D0057158 OUTOBER MeriLL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mn 20850 ROCKVILLE VEIRS DRIVE In Deard 9701 31. Date filed (Month, Day, Year) 32. Registrar's agnature State

DHMH 17 Rev 06-2011

Registrar

			1 - For State Registrar	State of	maryland /		artment of r <i>rtificate of</i>		Mental F	rygieni Reg. No		
£			Decedent's Name (First, Middle,	Last)			ramodio or	Douth	2. Date of	Death		3. Time of Death
	hysici		Helen L. Madara						Month OCTOI	Da	ay Year 1 入 えつ/	. 1 . 214
	Medio/ Examin		4a. Facility Name (If not institution,	give street and num	ber)		4b. City, Town, o	r Location of Dea			c. County of De	
			11922 Queen Str	eet			Fult	con			Howard	1
Fu	uneral			. Sex 7	. Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 Hr	8. Date of (Month)	Birth Day, Year	9. Bi	rthplace (State or Foreign country)
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and	*		Usual Residence of Decedent 10a. State 10b. County		10c. City. To	wn or Le	ocation					10d. Inside City Limits
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feath	TIS 2	Funeral	6264 Green View	12. Was Deced	lent Ever in U.S.	13.	Was Decedent of H		Specify Yes or	No-	14. Race - Am	
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Baltimore, permit. Pages 1 at Department of Hea	Important: any injury once.		21. Signature of Funeral Service Li	Thoma			remation 99 Freder			yland	l, Inc.	and 21220
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that the death cert	attending for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live bir	ome of pregnancy th 2 Petal dea		Ectopic pregnanc	1			23d. Date of de Month	elivery Day Year
nat the de	the	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknov	nt at time of death vn	ΣL	Other (specify) _			-		
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	6		30. Name and address of person	o completed cause	of death (Item 23a) (Type		J /T /	/	100	レルデ	, , ,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 31 per dvr g932/10-16-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Earvy Lee McNeill OCTOBER 2012 12:30 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOSPITAL OF BALTIMOR BALTIMORE N/A CITY Social Security Number 240-72-9322 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours Director 1 M 2 D F 08/06/1946 66 Carolina ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Baltimore Co. Gwynn Oak 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4806 Gwynn Oak Ave. 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the MeagnOnes. Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Purple Heart Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isaiah McNeill Arether McPherson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda McNeill(Cousin) 4801 Cordelia Ave., Baltimore, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
On-site Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Joseph Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Anoxic Brain Injure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Cardiorespiratory DAYS Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying 9 8 DAYS ardiac Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year detached 9 Unknown cate has been signed by ; page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonan Hypertension GERD 1 Yes 2 No 3 Probabiy 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 1 ☐ Yes 2 ☑ No this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Semura Gopie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEMIRA GOPIE MBBS SINAI HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner ..County of Death Baltimore Co 2019 North East Ave. Halethorpe Social Security Number 250 – 66 – 4854 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Days (Month, Day, Year) 04/06/1913 Hours S. Carolina Director 1 M 2 K F 99 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Co. Halethorpe 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21227 2019 North East Ave. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 K Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Family Farm 6th Gradé Farmer permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If Item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosa Gladden MacArthur Rivers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2019 North East Ave., Halethorpe, MD 21227 Louise Williams (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗀 Cremation 3 🔀 Removal from State New Lights Cem. 10/15/12 Orangeburg, SC 4 Donation 5 Other (Specify) Signature of Euneral Service Licenses 2greephoresore or Jr. Funeral Home PA utus 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End. Stage Dementia Physician/ ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and ifor usa as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of ifigury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No director, å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Affert 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier n's Rajapane MO 29c. License number 29d. Date signed (Month, Day, Year) 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD 21209 NSRajapaksemo 2835, Smin State Registrar

			State	te of Maryland / Dep			Mental Hy	giene	112	33118
			Registrar 1. Decedent's Name (First, Middle, Last)	Ce	ertificate of	Deam	2. Date of De	Reg. No. 4	116	00110
	Physicia		Paul Mosmiller				Month	Day	Year O/Z	3. Time of Death U:3:54 M
and the same	Medic Examir		4a. Facility Name (if not institution, give street an	d number)	4b. City, Town, o	or Location of Deat	1 0	4c. County		00.4
			University of Maryland	Medical Center		imore		, and a same,	o, Dodin	
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)				th v Year	9. Birthpla Country	ice (State or Foreign
	Director	Į.	218-42-6537 1 Dxm 2	□ F 66 Yrs.	Wichitis Days	Tiouis I Will	8/3/4	6	MD	")
	nd how at	5	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation					d. Inside City Limits
	laryla ga-f s iffied	ect	MD Baltimor		Essex				1,00	1 🗆 Yes 2 🔀 No
	or 28	٥	10e, Street and Number		10f. Zip Code			10g. Citizen of W	hat Countr	v?
	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show ice event, the Medical Examiner must be notified at its event, the Medical Examiner must be notified at	Funeral Director	1705 Glen Curtis	Road	21	221		US	A	
	item item		Arm.	Decedent Ever in U.S. 13. ed Forces?	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S	pecify Yes or No-	14. Race	e - American	
9	after I", or camir	Completed by	1 ☐ Never Married 2 ☐ Married 1 🛣	Yes 2 No s, Give	1 Yes 2 No		to moun, cto.)	Specify:	k, White, etc	
9500-61212	ours atura cal E	etec	3 Widowed 4 Divorced Year 15. Decedent's Education	or Dates.					Whi	
Ċ	72 h in "na Medik	ď	(Specify only highest grade comp	leted) (Give	edent's Usual Occup e kind of work done DO NOT use retired)	during most of wo	rking	16b. Kind of Bus	siness/Indu	stry
7 .	within jiene. er tha the l		Elementary/Secondary (0-12) Colle 10th	ege (1-4 or 5+)	Line W				GM	
פר	filed all Hyg	Be	17. Father's Name (First, Middle, Last)		111.0 11		ıme (First, Middle,	Maiden Surname)		
yland	Menta	은	George Mosmiller			Ida E	Petry			
Mar	shou and is m	- 1	19a. Informant's Name/Relationship (Type, Print,	Too. man	ing Address (Street					
e, S	and 2 Health em 27 ther tr		Sharon Mosmiller		Glen C	urtis F	Road Es	sex, MD	212	21
0	ge 1 g at of H : If ite or ot		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Remova	20b. Place of Disp cemetery, cre	matory or other plac		Date	20c. Location - 0	-	
baitimor	it. Page rtment o rtant: If njury or		4 Donation 5 Other (Specify)	Holly Hi						•
g	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service License	\mathcal{M}	2. Name and Addre	ss of Facility Co	onnelly e Balti	Funera more, M	il Ho 1D 21	me Essex 221
	7 11		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause	that caused the death. Do not ent	ter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,		pproximate
F	h sician/		Immediate Cause (Final	Ischemic Cardion	mus on those					nterval Between Inset and Death
1	Medical Examiner		resulting in death)	ue to (or as a consequence of):	AIGO DECIMA					
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5	requires that the dea h certifical been signed by the arending postbook to use as	Physician/Me	9 L ORKHOWN							
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cords,	equire een s	sted					1 💢	Yes 2 ∐ No 3	3 L Probab	oly 4 🗆 Unknown
3	has b ge 2 sk	Completed by					24a. Was autop	osy pr	rior to comp	findings available letion of cause of
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>	ding Physician: The la h. Affer this certificate he funeral director, page	% <u>To</u>		1 Inpatient 2 ER/Outpatie Date of injury 28b. Time o	nt 3 ∐ DOA	4 U Nursing F		dence 6 Other		
-	th. th. t After fune	Certificate:		(Month, Day, Year) injury	work		28d. Describe n	ow injury occurred	1	
2 :	Atter	rtifi	3 Suicide 6 Could not be	Place of Injury - At home, farm, str			28f. Location (S	treet and Number	or Rural Ro	oute Number,
<u>}</u>	lottne hospital or Attending Physician: The law requires that the dea h certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the allending physician and completely filled in by the funeral director, page 2 should be detached for user as the burial-transi		TE TIOMISTO	puilding, etc. (Specify)			City or Tow	rn, State)		
	Hospi 14 hou Funer tely fil	Medical	(Check 2 L Medical Examiner: On the	the best of my knowledge, death e basis of examination and/or inves	stigation, in my opinic	on, death occurred	at the time, date a	nd place, and due t	to the cause	(s) and manner stated.
	thin 2 the orthe	Me	only one) 3 Certifying Nurse Practit 29b. Signature and title of certifier	oner: To the best of my knowledge	, death occurred at t	he time, date and p	place, and due to the	he cause(s) and ma	anner as stat	ed.
	× × 2 0		1 11 1/11 1/11	l _ 11 =	29c. License			29d. Date signed (r, Year)
			30. Name and address of person who completed	rause of death (Itom 22a) (Time 1		73872		10/11/2	012	
						m NIZI	416 Rollin	more MD	7125	2.1
	Stat	е	31. Date filed (Month, Day, Year)	22 S. Greene 32. Registrar's Signature	1		10, 30111		-16	<u></u>
	Registra	ır	OCT 1 6 2012 /24	we p. park						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State	e of Maryland	Department of Certificate of		l Mental Hy		g. No. 20	12 3311
/ Physician/	Registrar 1. Decedent's Name (First, Middle,L.	^{ast)} Maria Fe	Lazaro-Mol	ina		2. Date of Deat	h	3. Time of Death
Medical Examiner		Fe	Lazaro Mol:			Month Septembe		1525 hrs
	4a. Facility Name (if not institution, g Johns Hopkins Bayview			4b. City, Town, or L Baltimore	ocation of Death		4c. County of De	atn .
Funeral			e (In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birt	N/A	Birthplace (State or
Director			6 Yrs	Months Days		-		eign Philippines Country)
, fa	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Locat	ion				10d. Inside City Limits
Ow any		ltimore			Dun	dalk		1 Yes 2XX No
nyland	10e. Street and Number	ittimore		10f. Zip Code			Og. Citizen of What C	ountry?
ith the Maryland 23a or 28a-f sho notified at once.	7812 St. Clai	re Lane		212	222		Philippi	nes
with t	11. Marital Status	12. Was Decedent		s Decedent of Hisp			14. Race - Am	nerican Indian, Black,
r death with or items 23 must be no Funeral	1 Never Married 2 Marrie	Armed Forces?	X No	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White, etc	
safter ral", o		ed If Yes, Give Year or Dates:	1 📑			lipino_		sian
hours fratur	15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade com College (1-4 or s	during m	nt's Usual Occupations of working life.			16b. Kind of Busines	s/industry
36 nin 72 than than dical				addan1 Co	aaratari		Medical	
5-0036 ed within 72 hour lygiene "natu other than "natu the Medical Exan Completed	12 Years 17. Father's Name (First, Middle, La	2 Years		edical Se	8.Mother's Name	(First, Middle, M	Maiden Surname)	
215 be file nital H riked ent, ti	Aniceto Laza	aro					delaMerce	
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical To Be Comple	19a. Informant's Name/Relationship Benita L. Greene	(Type, Print) (Cousin)					ber, City or Town, St	
nd 2 saith ar	Concordia Lazat	co (Mother)	20b. Place of Dispos			Pasader Date	na, Maryla 20c. Location - City	or Town, State
Ore of He ther t	1 Burial 2 Cremation	Removal from Sta	ate crematory or other	her place)		/11/2012		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 38a-f she flijury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Donation 5 Other Speci	fy:	Hilltop S		1	11/2012		ore, Maryland
Ba Depa Depa		(C) Du	da-Ruck 1	Funeral I	Home of	Dundalk, Maryland	Inc. 21222
Physician	23a. Pan I. Enter the disease, or confailure. List only one cause on		the death. Do not enter t	he mode of dying, s	such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Medical Examiner			herosclerotic Card	iovascular Dise	ease			Death
LAAIIIIIGI	or condition resulting in death)	Due to (or as a conse	equence of):					
5	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence of):	-				
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c						
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60, ate be hysici e buri	IF FEMALE:	23c. If yes, outcor	ne of pregnancy				23d. Date of deliv	rery
ox 68760 eath certificate be attending physic for use as the busician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	****	etal death 3	Ectopic pregna	ncy	Month	Day Year
), Box 6876(the death certificate by the attending phy- tched for use as the b Physician/Me	1 Yes 2 No 9 ✔ Unkno		time or death 5 Ot	ther (Specify)				
cords, P.O. B law requires that the d has been signed by the 2 should be detached upleted by Phy	Part II. Other significant condition	s contributing to deat	but not resulting in the u	underlying cause gi	ven in Part I.			to the cause of death?
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rds v requi						24a. Was a autop	sy prior t	autopsy findings available to completion of cause of
Records, The law requires ficate has been signate, page 2 should be Completed						perfor	med? death 2 No 1	
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n of ding Pl h. After funera	27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Day,Y			es 2 No	200, Describe i	iow injury occurred	
IVISION or Attend after death. Director: I in by the I	2 Accident Investig	ation 28e Place of In	jury - At home, farm, stre			28f. Location (S	Street and Number or	Rural Route Number, City
Division o spital or Attending rours after death frield in by the function:	3 Suicide 6 Could n 4 Homicide determine	ot be		,		or Town, S	tate)	
	29a. Certifier 1 Certifying Phys	ician: To the best of m	y knowledge, death occur mination and/or investiga	rred at the time, dat	te and place, and	due to the caus	e(s) and manner as s	tated.
To the Ho within 24 To the Fu completely	29b. Signature and title of certifier	and manner stated.		29c, License			29d. Date signed (
	D+ 1	Pana		O.C.N			September 29	, , ,
MA	30. Name and address of person wh	o completed cause of c	leath (Item 23a)					
18 av	Patricia Aronica-Pollak	MD. Assistant N	fledical Examiner	900 W. Baltim	nore Street, B	altimore, MI	O 21223	
State Registrar	31. Date filed (Month, Day, Year) OCT 1 6 2012		r's Signature					
DHMH 17 Rev 1/2001	ANI TO COLLE	turn S.	ORIGINA	L				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Raymond L. Miller, Sr. 0ct 1:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Towson Gilchrist Hospice Center 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Director 219-70-1902 1 K M 2 🗆 F Yrs Sept. 17,1957 Maryland Usual Residence of Deceder Paga 1 and 2 should be fliad within 72 hours after death with the Maryland ment of Health and Mental Hygiene. The street of 18 marked other then "natural", or itama 23a or 28a-f show jury or other traumatic event, the Medical Examinar must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗆 No Baltimore City MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 5050 Orville Avenue 21205 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married ě Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Commericial Heating Elementary/Secondary (0-12) College (1-4 or 5+) and Air Conditioning HVAC Technician 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ruby Alice Tyler Henry J. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5050 Orville Avenue Baltimore, MD Mrs. Diana K. Miller (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State Dapartment of Important: If any injury or once. Hilltop Service Corp. 10/12/2012 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee cott P. 22. Name and Address of Facility Gardner Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition Pnysician MRTASTATIC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate couse Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The iaw raquiras that the daath cartificata ba executad within 24 hours after daath.

To the Funeral Director: After this cartificata has baan signed by the attanding physician and compietaly fillad in by the funeral director, page 2 should be datached for use as the burial-transit Exam Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? Completed by CHRONIC OBSTRUCTIVE PULMONARY DISEASE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CORUNARY ARTERY DISEASE 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and the time as scaled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mitchell. III Month Day Year Clarence M 6:551 October Medical 10 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Season's Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 12 14 | 12 14 | Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 216-36-5246 Director MN 72 Usual Residence of Decedent er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No NA Baltimore MD 10e, Street and Number 10g. Citizen of What Country? U.S.A. Funeral 21215 6306 Wallis Ave death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc 1 Never Married 2 X Married \$ Maryland 21215-0036 hours after 1 ☐ Yes 2 🗓 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 tof Health and Mental Hygiene.
If item 27 is marked other than "r College (1-4 or 5+) 5yrs+ Elementary/Secondary (0-12) Self Employed 12th grade Business Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Juanita Jackson Clarence M. Mitchell Jr. permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6306 Wallis Ave, Baltimore, Md 21215 <u>Mitchell-Wife</u> т. Joyce Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2012 Baltimore, Md On-Site Sanature of Funeral Service Line see 22. Name and Address of Facility t Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21215 Md Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease Or Injury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Pother Specify ent his Spice 2 🗗 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MS RajapaheMD 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0057465 10/11/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 61 5703 Baltimore 21209 NS Rajapa KEL MO 2835 Smith AV MD 31. Date filed (Month, Day, Year OCT 1 6 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 29d, per MD G932, 10/16/12 trt. State of Maryland 7 Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1259 AM Rhonda Megby 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. mary's Hospice of St. Mary's Callaway If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours **Director** 214-68-9714 1 M 2 XF June 17, 1956 Kentucky 56 or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 V No MD St. Mary's Hollywood 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

Department of Health and Mertal Hygiene.

The Mertal Hygiene of the Tis and Mertal Hygiene.

The Medical Examiner must be no any injury or other traumatic event, the Medical Examiner must be no any injury or other traumatic event, the Medical Examiner must be no Funeral 44543 Eleanor Court 20636 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 X Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) landscaping 0 gardner 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Thayer Lloyd Carpenter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20636 44543 Eleanor Court Hollywood, MD Sally Adams/daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signat F neral S State Anatomy Board 655 W. Baltimore Street MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury that initiated events executed signed by the attending physician and id be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe Jas Hospital or Attending Physician: The 24 hours after death. within 24 hours after death.

To the Funeral Director; After this certificate I 2 🗌 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 1 Yes 2 1 မ ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at use Certificate: Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/21/12 30. Name and address of who completed cause of death (Item 23a) (Type, Print) Schmidt 40900 Merchants Lane Suite 205 Leonardtown, MD 20650 Jennifer 31. Date filed (Month egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year 4:29 PM 0 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITG land enera Himore last birthday) If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min (140 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ģ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Black If Yes, Give Year or Dates Specify. Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Elementary/Seconday (0-12) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ ernon core . Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bowen 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of Date cemetery. crematory or other place 19 21. Signature of Funeral Service Licensee MarchE 22. Name and Address of Facility 0 North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ omyopathu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Kidney 24a, Was an hin 24 hours after death.

the Funeral Director: After this certificate has I autopsy performed 2 No 1 Yes 25. Was case referred medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 1 No Other: မှ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Man, er of Death Certificate: 28b. Time of 28c. Injury at ✓ Natural 5 \square Pending Accident 1 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one within To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar 30_Name and addre

of person who completed

6 2012

ause of death (Item 23a) (Type, Print)

32. Registrate

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:10 A Medical Name (if not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Medica Lt. MURE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birtholace (State or Foreign Age (In yrs. last birthday, **Funeral** Months 65 219-52-2532 MD **Director** 1**X** M 2 □ F 01-10-47 28a-f shov 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 ☐ No Baltimore NA MD 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 21213 1617 N. Milton Avenue "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African Completed by 1 X Never Married 2 Married 1 **K** Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: American 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, should be filed within 7 and Mental Hygiene. College (1-4 or 5+) Flementary/Secondary (0-12) Canteen Vending Co. Truck Driver 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simmons ည Mister Essie Pernell Grafton t. Page 1 and 2 should b rtment of Health and Mer rtant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 19a. Informant's Name/Relationship (Type, Print) Mary R. Glen-Girlfriend injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-12 Woodlawn, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran: that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial Physician/Medical Box 68760 as t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 Lyes 2 L 9 Unknown Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performe 2 No 2 No certificate 1 🗌 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Inpatient မ 1 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No 124 hours after death.

The funeral Director: Af objetely filled in by the filled in t Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) 29b. Signature and title of certifie

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ 09 7.41 2012 MITCHELL JANDRA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of MARYLAN BALTIMORE NA Cont 1/2 NOSICAL Birthplace (State or Foreign Country) if Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year 12-25-58 7. Age (In yrs. last birthday) Security Number **Funeral** Min Hours 214-64-6393 MD **Director** 1 □ M 2 🛈 F 53 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral or items 23a USA 1316 McHenry Street 21223 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 X Never Married 2 Married ð Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: Specify: American If Yes, Give "natural", 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Nursing Assistant Health Care 12th Grade 2vrs. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental h Butler permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ည Elsie Mitchell James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 W. LaFayette Avenue Baltimore, MD 21217 19a. Informant's Name/Relationship (Type, Print) Christina Moore-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 10-15-12 Dundalk, MD Trinity Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. Signature of Funeral Service Licensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine frany, leading to immedia cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 1 Yes 2 Dunknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an erai uirector. After this certificate has filled in by the funeral director, page 2 autopsy performed? 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital: 2 W No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 🗆 Yes 2 🗆 No 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pendina injury s after death. Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital c within 24 hours at To the Funeral D completely filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year 29c. License number D006901 M. 7

Registrar
DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MS

32. Registrar's Signature

EDLARSS

BRINN

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kathy Jean Moats State of Maryland / Department of Health and Mental Hygiene 2012 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death 3. Time of Death Medical Examiner October 7, 2012 1414 hrs 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death c. County of Death 2016 Kelbourne Road Rosedale **Baltimore County** 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Director M 2 F 2 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Rosedale If iton 27 is marked other than "natural", or items 23a or 28a-f sho her traumatic event, the M-dical Examiner must be notified at once. 1 Yes 2 No hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) ore, MD 21215-0036 (ss 1 and 2 should be filed within 72 P of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Insurance 9 COM 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (T 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20a. Method of Disposi 20b. Place of Disposition (Name of cemetery, Location - City or Town, State Baltimore, Pages 1 2 Cremation 3 Burial Removal from State portant: Donation 5 Other Specify 21 Signature of Funeral Service Licensee M.0144 en D. Lohi 23a. Pan I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval /Medical Between Onset and a Hypertensive Atherosclerotic Cardiovacsular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical AMENDED 23a,pt.II,27,per me,g932 10-19-12 sm #10b,c,perFH,g932,10/16/12,WS X UNPENDED attending physician for use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months' Month Day Year Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 ✓ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Lung Disease; Recent Pneumonia 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy performed? 1 🗸 Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Other₄ Inpatient 2 ER/Outpatient 3 DOA 1 🗸 Yes Nursing Home 5 Residence 6 ✔ Other: Scene 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) within 24 hours a determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hallan O.C.M.E. October 8, 2012 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year State

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month E1ba Moorin 2012 Medical 9:20 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arden Court Assisted Living Silver Spring Montgomery Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Months Hours Director 212-84-5005 1 M 2 X F 94 Usual Residence of Dece Oct. 2, 1918 Puerto Rico ed other than "natural", or items 23a or 28a-f show event, the Med of Exeminer must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mantal Hygiane. ant: If item 27 is marked other than "natural", or items 23s or 28s-f sho 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 E. Franklin Ave. 20901 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XXNo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ģ Baltimore, Maryland 21215-0036 1XXYes 2□No Specify Puerto Rican Completed 3 X Widowed 4 Divorced Specify Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francisco Rodriguez Tomasa Delgado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory F. Moorin / Son 9509 Curran Rd., Silver Spring, MD 20a. Method of Disposition parmit. Page 1 a
Department of H
Important: If ite
any Injury or ott 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10/14/2012 Beltsville, MD 21. Signature of Funeral-Ser MO0382 AS Name and Address of Facility Cremation Services 933 Gist Ave., Silver Spring, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition emente Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): usa as tha burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ate has baen signed by tha attending physician page 2 should ba detachad for usa as tha buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month 1 Yes 27 Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy
performed?

Yes 2 No 1 Yes 2 No To the Hospital or Attending Physiclan: I within 24 hours aftar death.

To the Funeral Director: Aftar this certifics complately filled in by tha funaral director, I 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 1XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 698 12

OV State

Registrar DHMH 17 Rev 06-2011 MONTGOHER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 33128 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edwin Willard May 2012 October Medical 1:04 P M Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Citizens Care and Rehab. Center Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days (Month, Day, Year) 198-22-8059 Director 1 □**XM** 2 □ F 82 May 19, 1930 Usual Residence of Decedent Pennsylvania 27 is marked other than "naturel", or items 23a or 28a-f show treumetic event, the Medical Examinar must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits PA Adams 1XXYes 2 No Gettysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 N. Chamberlain Ct. 17325 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces <u>۾</u> 1 Never Married 2 X Married TXTYes 2 No If Yes, Give Year or Dates. 1950-72 Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Intelligence Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ည and 2 should be 1 Thomas May Hammaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Gwendolyn M. May / Wife 9 N. Chamberlain Ct., Gettysburg, PA other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Importent: If it
eny Injury or o Date 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) Uniformed Sers. Univ. 10/05/2012 Bethesda, MD 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Rapp Funeral and Cremation Services M00382 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 933 Gist Ave., Silver Spring, MD 20910 SUPRANUCLEAR PALSY Immediate Cause (Final ROGRESIIVE enset and Death Physician/ disease or condition Medical resulting in death) Duesto (or as a consequence of) Examiner HEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the deeth certificate be executed end -trans been signed by the attending physician eshould be detached for use as the burial-Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2: autopsy perform Yes 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident Investigation 1 Tes 2 No 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print)

PROPERCY, 196 TTDWE, PROPERCE, NI 2190

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 12, 2012 Physician/ 5:30 A M Caro1 Joan Mertz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. 060-24-3840 Director 1 □ M 2 🗓 F March 1, 1931 New York 81 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 ☐ Yes 2 💆 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 20854 United States 11125 Post House Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or any injury or other traumatic event, the Medical Examinans. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Assistant Facility Manager Golf Course 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Ruth Freiberg Charles F. Breswitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11125 Post House Court, Potomac, Maryland 20854 Eugene H. Mertz / Husband 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 18 Vestal Hills Memorial Park 1 🕅 Burial 2 🗌 Cremation 3 🗍 Removal from State 2012 Vestal, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 Mystatte Busu M01305 23a. Part 1. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, should or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Failure 10 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury Due to for as a consequence of): attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Kidner Discase 1 Yes 2 KNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funerel Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to **Division of Vital**

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State Registrar

Medical

29a. Certifier

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

OCT

1 6 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10110 Sayva

Molecular Drive Rockville MO

12012

32. Registrar's Signature

1 McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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	Funeral				7. Age (In yrs. la		If Under 1 Months D	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			Birthp Count	lace (State or ry)	Foreign
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	item item		11. Marital Status	12. Was Deced	lent Ever in U.S	S. 13. \	Was Decedent f Yes, specify	t of Hisp Cuban,	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)			e - America k, White, e		
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Ba	permit. Page 1 end 2 Department of Health Important: If item 2; any Injury or other tonce.					l M	iller-	Dip.	pe1]	Fune	ral Hom altimor	e,	Inc.	1206		
			23a. Part J. Enter the disease, or shock, or heart failure. List o	complications that ca	aused the death	n. Do not ente	er the mode o	f dying,	such as	cardiac o	r respiratory ar	rest,			Approximate Interval Betw	
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>	7 # # = =	Certificate:	3 ∐ Suicide 6 ∐ Could r 4 ☐ Homicide determi	ned 28e. Place	of Injury - At ho g, etc. (Specify		eet, factory, o	ffice			28f. Location (3 City or Tox			er or Rural	Route Numbe	er,
_	the Hospital of thin 24 hours a the Funeral Dimbletely filled in	Medical		Physician: To the be												
	the H tin 24 the Fu Tplete	Me	only one) 3 X Certifying	caminer: On the basis Nurse Practitioner:												ner stateu.
	ढ़ ₹ ७ ७		29b. Signature and title of certifier	A O A	000	10	29c. Li	cense r	number	77	2	29d. D	ate signed	(Month, E	ay Year)	1 3
					. 00	994		<u>ار</u>	200	× [<	×		10	111	100	10
	61		30. Name and address of person v TRACIE L. MOR				rint) Y VALL	FY 1	RD.	ттм	ONIUM,	MD	ا #) (إ ۾			
	Sta	te	31. Date filed (Month, Day, Year)	/ 32. Re	gistrar's Signat	ure,	=				-11-0119	/	/("	-		
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DHMH 17 Rev 06-2011

1:20 p.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wanda J. Newman Month 2012 4:40 PM CTOBER Medical 4a. Facility Name (if not institution, give street and number, Examiner 4c. County of Death 4b. City, Town, or Location of Death FRANKLIN BALTIMORE QUARE HOSPITAL OSEDALE Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) May 31, 1931 Months 219-28-2138 Hours Director 81 1 □ M 2 🛂 F 28a-f shov 10a. State 10b. County ir than "natural", or items 23e or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Essex 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2414 Beach Avenue witht Funeral 21221 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after coppartment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injury or other treumetic event, the Machanian once. 1 Never Married 2 Married Black, White, etc. \$ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Completed 3 X Widowed 4 ☐ Divorced Specify. Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKET 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+ own home Be ンドシアムマ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James C. Trenum Harriett White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2414 Beach Avenue Baltimore MD 21221 Pamela Hoesch /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Bayview Crematory 10/15/12 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Other (Specify) 21. Signature of Fun Service Lig 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SCHEMIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ATERAL Sequentially list conditions Examine frant, leading to immediate cause. Enter Underlying Cause (Disease or injury ed by the attending physician and detached for use as the burial-transit or Attending Physiclen: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 1 ☐ Yes 2 1 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Yes 2 12 No ne Hospital or Attending Physin 24 hours after death.

Funeral Director: After this optetely filled in by the funeral dir 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 W Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier RES 0000 weare 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. ERIC 9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD 2123; SWEARENGEN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 16 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 331 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Oc tober Physician/ 1800 Frank Novak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisburg Wicomico Salisbury Rehabilitation a Nursing Ctr. 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min (Month, Day, Year) Director 194-10-6940 1 X M 2 🗆 F 94 Mar 6, Pennsylvania ed other then "naturel", or items 23a or 28e-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Delmar 1 Yes 2X No DE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 35288 Susan Beach Road 19940 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 137-58 Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) rould be filed within 72 and Mental Hyglene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 mi<u>litary officer</u> Armv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Novak Fannie Kovasec other treumetic end i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Gibson/daughter 35288 Susan Beach Road Delmar, DE 1 end 2 s of Heelth Item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pege 1 permit. Pege 1
Depertment of
Importent: If it
eny injury or o 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Funeral Service L 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): To the Hospitel or Attending Physicien: The iew requires that the deeth certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical From k Novak Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Other (specify) Q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated itte of certifie 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 28 ess of person who completed cause of death (Item 23a) (Type, Print) IVIC DISOMIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 per FH G950 4/24/2014 JH

			1 - For State Registrar	e of Maryland / De C	Certificate of		Mental Hy	Reg. No. 201	2 33133
	Physicia	an/	1. Decedent's Name (First, Middle, Last)				2. Date of De	ath	3. Time of Death
al Sales and	Medio Examir	cal	Muriel M. Nunn 4a. Facility Name (if not institution, give street and	number)	Ab Oits Tassa	and another of Doo	100nth	10 Day 2012 Year	
	Exami	ler	Montgomery General Hos	01ney	or Location of Dea	tn	4c. County of D. Montgom		
	Funeral	Г	5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year Months Days				Birthplace (State or Foreign Country)
	Director		228-32-5 404 1 ☐ M 2 X Usual Residence of Decedent	85 Yrs			4/21/19		rginia
	yland -f sho ed at	ctor	10a. State 10b. County MD Silver Spring	10c. City, Town or Montgome					10d. Inside City Limits
	ne Mar or 28a notifi	Director	10e. Street and Number	Honegome	10f. Zip Code				1 X Yes 2 □ No
	with the s 23a c ust be	Funeral	3203 Ludham Drive		20906			10g. Citizen of What USA	Country?
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 N	Give	3. Was Decedent of I If Yes, specify Cub		specify Yes or No- to Rican, etc.)	Black, WI	nerican Indian, nite, etc. 1ack
2-0	hours matura dical E	Completed	15. Decedent's Education	r Dates. 16a. De	cedent's Usual Occu	pation		16b. Kind of Busines	ss/Industry
121	thin 72 the. than "	mo		e (1-4 or 5+)	ve kind of work done . DO NOT use retired	during most of wo	orking		oo, maasti y
d 2	led wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Last)		eacher	18 Mother's No	ıme (First, Middle,	Private	
/lan	d be fi Vental arked atic ev	ည	Maurice Norbrey			Nannie		iviaideri Surriame)	
Maryland 21215-0036	shoul rand l		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or R	ural Route Number	; City or Town, State,	Zip Code)
ē,	and 2 s Health tem 27		Barbara Mayfield/Daught 20a. Method of Disposition		Lugnam .	brive Si.		ing, MD 209	
Baltimore,	:. Page 1 tment of tant: If it jury or c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal file 4 ☐ Donation 5 ☐ Other (Specify)	rom State cemetery, c	rematory or other pla on Nation		Date /19/12	20c. Location - City Suitland	·
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee					arch Funer d, MD 2074	
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause or	at caused the death. Do not e					Approximate Interval Between
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	, =	iner	Sequentially list conditions, it any loading to immediate cause. Enter Underlying	or as a cultiequence o :		Failu	1.00		
	ecuted and I-trans	xan	Cause (Disease or injury that initiated events c.	to (or as a consequence of):	enay	laiw	ve	[]	
0	icate be executed physician and is the burial-transit	edical Examiner	d d	to (or as a sonsequence sij.					
8760	ifficate ng phy as the		IF FEMALE:						
Box 68	death certif ne at ending ied for use a	ian/l	23b. Was decedent pregnant in the past 12 menths?		Ectopic pregnan	су		23d. Date of d	
B	requires that the death certifiches signed by the attending should be detached for use as	Physician/N	1 ☐ Yes 2 ☐ No 4 ☐ P	regnant at time of death 5 nknown	☐ Other (specify) _			Month	Day Year
P.O.	s that t	by P	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying o	ven in Part I.	23e. Did to	bacco use contribute	to the cause of death?
rds,	equires een sig nould b	sted	CHOICE WITH	L CAMADONA	neic / A	100/100	1 U Y	es 2 No 3 No	Probably 4 Unknown
Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed	2 (voice only	Hemilan	27/11	12/2000	24a. Was a autops perform	sy prior to	utopsy findings available completion of cause of
<u>e</u>	rsician: The law is certificate has but director, page 2 s	Be Co	25. Was case referred to medical	·	26 PI	ace of Death (Che	1 🗌 Yes	2 1	es 2 No
 	hysici his cer al direc	일		Unpatient 2 ☐ ER/Outpati	Oth	er:		ence 6 Other (Spe	ecify)
Division of	ding P th. After t funers	Certificate:	1 Natural 5 Pending (M	te of injury onth, Day, Year) 28b. Time injury	work	y at		w injury occurred	
Sio	Atten er deal ector: by the	<u>₩</u>		ce of Injury - At home, farm, s		Yes 2 ☐ No	28f. Location (St.	reet and Number or Ri	ural Route Number
≧ ຼ	ital or urs afte ral Dir lled in	S	bul	Iding, etc. (Specify)		Jan	City or Town	, State)	
:	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificacompletely filled in by the funeral director,	Medical	29a. Certifier (Check only me) Certifying Physician: To the Company me) Certifying flurse Practition	asis of examination and/or inve	estigation in my opinio	in death accurred	at the time date on	d place and due to the	001100/01
	Voit Con		29b. Signature and title of certifier	Sun	29c. Lisense	500		9d. Date signed (Mon	7
	10 av		30. Name and address of person who completed ca	use of death (Item 23a) Type	ALCIPL		109 Prinding	ce Philip	Drive
	State Registra		31. Date filed (Month, Day, Year) OCT 1 6 2012	E gistrar's Signature —	Sand J		, 1111		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			04.4.	epartment of Health and	Mental Hyg	iene	00101
			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death		eg. No. 2012	33134
	Physicia Medi		MARGARET J. NEWELL		2. Date of Death Month OCT •	Day 2012	3. Time of Death 2:45a. M
and the same	Examir	ner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
-	Eunaval	۳	Frederick VilleNursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Catonsville		Baltim	
	Funeral Director		214-30-4490 1 D M 2 1 78 Yr	Months Days Hours Min.	(Month, Day,	Year) Count	lace (State or Foreign ry)
	D W		Usual Residence of Decedent		OCT 21		MD
	ırylanı a-f sh iled a	Director	1			10	Od. Inside City Limits
	he Ma or 28,	į	MD Anne Arundel Glen 10e. Street and Number	Burnie 10f. Zip Code	-	0g. Citizen of What Count	1 Yes 2 X No
	ns 23a	Funeral	918 Edgerly Road	21060	''	U.S.A.	ı y r
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e Specify: WHI	tc.
21215-0036	iin 72 hou e. han "natt	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	king	16b. Kind of Business/Ind	ustry
	d with tygier ther th	Be C		MEMAKER		House	
Maryland	lld be file Mental F larked o atic eve	To E	17. Father's Name (First, Middle, Last) Bernice S. Vogtz		ne (First, Middle, Mi ine Phie		
	d 2 shou alth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, Print) ROGER NEWELL – SON 54	lailing Address (Street and Number or Run 21 James Town Ct	ral Route Number, C	City or Town, State, Zip Co	ode) 21229
Baltimore,	of He of He If item		20a. Method of Disposition 20b. Place of D	sposition (Name of crematory or other place)		20c. Location - City or Tov	
ţi.	trent of tant: If it tant: If it ijury or o		4 Donation 5 Other (Specify)		16 2012	BALTIMORE,	MD
Baj	permit. Page 1 a Department of H Important: If its any injury or ot	,	21. Signatura of Funeral Service Licensee	22. Name and Address of Facility MARCH FUNERAL HOME		BOO WABASH A	VE. 21215
			23a. Par 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres		Approximate Interval Between
-	Physician Medical	0.01	Immediate Cause (Final disease or condition resulting in death)	rdinminathy			Onset and Death
1	Examiner		Due to (or as a consequence of).	0, 5			
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury)				-
	cate be executed physician and s the burial-transif	I Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
9	ate be ohysici the bu	dical	d				
687	ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				
Box .	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliver Month E	y Day Year
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Division of Vital Records,	iw requ	Completed			24a. Was an	24b. Were autops	y findings available
Re	The la ate ha page	Som			autopsy performe	ed?_ death?	pletion of cause of
ta	cian: ertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec			
₹	Physi this c	6	1			ce 6 Other (Specify)	
0 0	nding tth. ; After e fune	cate	1 Natural 5 Pending (Month, Day, Year) injur 2 Accident Investigation		28d. Describe how	injury occurred	
1810	• Atter er dea • ector • by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm,			et and Number or Rural R	oute Number,
2	ital or urs aft ral Dii		building, etc. (Specify)		City or Town,	,	
	the Hosk nin 24 ho the Fune upletely fi	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deal process of examination and/or in the basis of examination and the basis of examination an	estigation, in my opinion, death occurred a	t the time, date and i	place, and due to the caus	e/s) and manner stated
	Vith vith COT		29b. Signature and title of certifier Raymonu MWL MD	29c. License number	290	d. Date signed (Month, Da	ıy, Year)
	n,		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		1-1-11-6	
	XV		31. Date filed (Month, Day, Year) OCT 1 6 2012 Reserved A. January	15 Mills MD ZIII	17		
	Stat Registra	ır	31. Date filed (Month, Day, Year) OCT 1 6 2012 Series 32. Registrary Signature April 1	and s			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #12 Per ANA BD G933 11/09/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2012 4:30 Рм David Graves Orr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 2 Court Drive Joppa If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Country) Director 217-58-7110 1 X M 2 - F 60 1952 April 13, Maryland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits the Maryland Completed by Funeral Director must be notified 28a-f 1 Yes 2 X No MD Harford Joppa 10e. Street and Numbe 0 10f. Zip Code 10g, Citizen of What Country? 23a 21085 USA 2 Court Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. ral", or iter Examiner Armed Forces?

1 Yes 2 1 No
If Yes, Give 107 Black, White, etc. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1970–76 White 1 ☐ Yes 2 X No Specify: 'natural", Specify: 3 Widowed 4 Divorced th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) small arms repair tech Armv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ William Graves Orr Minnie Marie Griest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Court Dr; Jopla, MD 21085 Deborah Orr - wife item 27 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or ot once, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Othe (Specify) Signatur of Fu 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Apter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death peart failure. List only one cause on each line Immediate Cause (Finel Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): 5 malti Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the attending physician and the for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law I hin 24 hours after death. autopsy 2 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital Other: မ 1 Yes ER/Outpatient 3 DOA 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) an D45390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Drive Myo MIN #409 Bel Air ,Md 21014 31. Date filed (Mo Registrar's Signatu State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mary E. Poling 0035 A M Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Agnes HOSPITAL Baltimore N/A If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 213-20-8346 **Director** 1 🗆 M 2 💢 F 87 Yrs. Oct. 2, 1925 Usual Residence of Decedent Maryland 28a-f show 10a. State 10h County 10c. City, Town or Location Director 10d. Inside City Limits N/A Maryland Baltimore City 1 X Yes 2 No 10e. Street and Number 9 10f. Zip Code Examiner must be 10g. Citizen of What Country? Funeral items 23a 1733 Wilmington Avenue 21230 United States Page 1 and 2 should be filed within 72 hours after death we ment of Health and Mental Hygiene. Fatter If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Joseph L. **McGee** Annie Kidd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lewis J. Poling / Son Department of Health Important: If item 27 any injury or other to once. 1733 Wilmington Ave., Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Metro Crematory Inc. 10/16/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee ALVSON K Taylor 299 Frederick Road, Baltimore, Maryland 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physicia / sersis due to clostaidium difficile colitis disease or condition Medical resulting in death) Examiner Usinasy tract intection WICEK Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Status epilepticu Week and Due to (or as a consequence of resulting in death) Last physician Physician/Medical the as attending IE EEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month been signed by the a should be detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Coronary artery disease, Hypertension, Diabeter Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Atrial dibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No peripheral Vayanlas 24a. Was an autopsy disearc perform certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 💆 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28a. Date of injury Certificate; 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 25499 October 14 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nadipelli S. Caton Avenue 900 Baltimore,

Registrar

31. Date filed (Month, Day, Year)

Protzmann, Can

			Please Type or Print in Black State of Maryland / Dep	Indelible Ink. Ensure All Copie partment of Health and Mental Hy	9
			1 - State Registrar C6	ertificate of Death	Reg. No. 2012 33137
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Carl Protzmann, Jr.	2. Date of De Month	Day Year 1:16 A M
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c County of Death
	Funeral		Franklin Square Hospital Cente 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		
	Director		216-50-0027 1 2 M 2 □ F 64 Yrs.	Months Days Hours Min. (Month, Da	20,1948 Baltimore,MD
	and show	호	10a. State 10b. County 10c. City, Town or L		10d. Inside City Limits
	Mary 28a-f notifie	Director		rkville	1 ☐ Yes 2X No
	with the is 23a or	Funeral D	8320 Overmont Road	10f. Zip Code 21234	10g. Citizen of What Country? United States
	r death or item oiner m		11. Marital Status 1 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2N No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
9036	rs afte ıral", c	ed by	3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2A☐ No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:	Specify: White
15-0	72 hou n "natu ledica	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
212	within giene. er thai		College (1-4 or 5+)	DO NOT use retired) aftsman/Engineer	Helmut Guenschell Inc.
/land	d be filed Mental Hyg arked oth	To Be	17. Father's Name (First, Middle, Last) Carl Protzmann	18. Mother's Name (First, Middle, Gertrude Kur	Maiden Surname)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Power of 19b. Mai David Mueller Attorney 1015	ling Address (Street and Number or Rural Route Number S. Main Street, Bel	r, City or Town, State, Zip Code) Air, MD 21014
imore	Page 1 ar nent of Hu ant: If iter ury or oth		20a. Method of Disposition 1	ematory or other place) October Uneral	20c. Location - City or Town, State Forest Hill, MD
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	Rel Air 16, 2012 Rel Air 16, 2012 Vans Funeral Chapel 8 8800 Harford Road Park	& Cremation Services
			shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respiratory are	rest, Approximate Interval Between
w Sy	Ph _{sician} Medical	P) 7	Implediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Embolism .	Onset and Death
	Examiner		Sentice	hack	
	ed sit	Examiner	Seque, Itally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0 1	
	be executed sician and burial-transit		that initiated events resulting in death) Last c. Due to (or as a consequence of):	fection	
09		dical	d		
687	certifica Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		
. Box 6876	The law requires that the death certificate to also has been signed by the attending physpage 2 should be detached for use as the	Physician/Medic	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
, P.O.	s that thigned by be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the	233. 214.	bacco use contribute to the cause of death?
ords	require been s should	leted	-		/es 2 □ No 3 □ Probably 4 ☑ Unknown
Records,	sician: The law of certificate has the lirector, page 2 s	Completed			sy prior to completion of cause of
ta		Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	Z No Thes Z No
<u> </u>	ding Physi th. After this c funeral dir	<u>۾</u>	1 ☑ Inpatient 2 ☐ ER/Outpatie 27. Manyer of Death 28a. Date of injury 28b. Time of		ence 6 Other (Specify)
ono	ending sath. or: Afte he fun	ficat	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 \sum Yes 2 \sum No	ow injury occurred
Division of Vital	tal or Att rs after d al Directo led in by t	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Med	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death only one) 2 Medical Examiner: On the basis of examination and/or investorily one) 3 Certifying Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred at the time, date ar	ad place, and due to the cause(s) and manner stated
	con with		29b. Signature and title of sertifier Yip MD	29c. License number	29d. Date signed (<i>Month, Day, Year</i>)
	19 11,		30. Name and address of person who completed cause of death (Item 23a) (Type, David Kip 7000 Franklin Squ	print) Drive. Baltimore	.MD 21231.
	State Registra	_	David Lip 7000 Fronklin Son 31. Date filed (Month, Day, Year) OCT 1 6 2012 2 Registrar's Signature	del	
DLIN	1H 17 Boy 06-2	014	WI WILL AND THE PARTY OF THE PA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Pipkin, Sr. Edward 9:30 0 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Rosedale baltimore ranklin If Under 1 Year 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Days Min (Month, Day, Year) Director 220-20-1941 Usual Residence of Deced 1 **X** M 2 □ F July 27, 1928 Maryland Maryland 84 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director or 28a-f MD 1 Yes 2 X No Parkville Baltimore 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral Apt. 3207 21234 United States 8810 Walther Blvd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. "natural", or à 1 Never Married 2 Married Yes 2 🙀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I once. Steel Industry 4 Years Electrician 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Barzack John Pipkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elkton, Maryland Senator E. J. Pipkin(Son) 400 Patriots Way 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1x Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Stanislaus Cem. 10/15/2012 Baltimore, Maryland St. Donation 5 Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. of Funeral Service Licens ennis Signatu 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheek, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ ocardial disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has 1 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006328 tevl

State Registrar 31. Date filed (Month, Dav. Year)

9000 Franklin Square Drive

Balto. MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 200 Jesse G Phillips Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arudel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 219-26-8520 1 M 2 🗆 F 73 Feb. 21 1939 VA Usual Residence of Decedent if Heelth and Mentel Hygiene. Item 27 is marked other then "neturel", or iteme 23e or 28e-f show other treumetic event, the Medical Examinar must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Pasadena Maryland Annne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 1331 Old Mountain Road 12. Was Decedent Ever in U.S. Armed Forces?

1

Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. é 1 Never Married 2 Ty Married should be filed within 72 hours after White 1 ☐ Yes 2 X No Specify Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Anne Arundel County 12 Police Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Bales Gladys Landon Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1331 Old Mountain Road, Pasadena, MD 21122 parmit. Pege 1 end 2: Dapertment of Haeith Vivian M. Phillips (spouse) Baltimore, Date 17 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. Baltimore, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) . Signature Funeral Service Lice 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, of complications that caused use shock, or heart failure. List only one cause on each line. ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate Interval Betw Onset and D CHRONIC BASTRICTIVE Physician/ Fulmonak disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of: To the Hospital or Attending Physician: The iew requires thet the death certificate be executed within 24 hours after deeth.

To the Funerei Director: After this certificate hes been signed by the attending physician and completely filled in by the funerei director, page 2 should be deteched for use as the buriel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy Yes 2 4 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check In this in Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause and manner as stated. only one 29b. Signature and title of certifier eted case of death (Item 23a) (Type, Print) 10+ address of person who compl Gien Burnie mo 2016 ARA 501 32. Registrar's Signature State 1 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 15, 2012 Ethel V. Porter 1:15 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Angels Among Us Assisted Living Middle River Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) Days 215 12 4476 **Director** 92 1 🗆 M 2 🔀 F Sept. 7, 1920 Maryland Usual Residence of Decedent 28a-f show Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Middle River 1 Yes 2 X No 10e. Street and Numbe 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 12820 Eastern Avenue 21220 USA items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No 9 Black, White, etc. þ within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", If Yes Give 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed الم عد Than المد المو Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 12 Own Home other 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental | 7 is marked o ဂ္ James S. Ward Bertha M. Olfers 1 and 2 should be f Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 James Ronald Porter (Son) 507 John Avenue Baltimore, Maryland 21221 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o
once. o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Inc. 10/16/2012 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A Kn W 1407 Old Fastern Avenue Essex, Maryland 21221 23a (part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physici_n TE RIOSC Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence on) the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year Yes 1 ☐ Yes ∠ ■ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? GENERAL DE BILL T 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes Within 24 hours area. To the Funeral Director, After this cerum. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 🔀 No 1 🗌 Yes Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending ☐ Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 🛮 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certi

DHMH 17 Rev 06-2011

Registrar

8022 BELAIR ROAG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

104N 5 nth, Day, Year) 17728

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20/2 0630 M 02 9010 Medical 4a. Facility Name (if hot institution, give street and pumber) Examiner 4b. City, Town, or Location of Death 4c. County of Death Md vem 1751 rove 1105 herg UYS Dry & ME 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Months Hours Min Director 577-26-4779 1 □ M 2 💢 F 100 Sept. 1, 1912 Maryland 27 Is marked other then "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Montgomery Village 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19310 Club House Rd. 20886 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. and Mental Hygiene. Is marked other then "natural", 3 X Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Employed Sales / Antiques Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert Bostetter Newton Annie Edith Zuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 Is any Injury or other trau Linda Lieberman / Niece 23402 Clarksridge Rd., Clarksburg, MD timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2XX Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 10/06/2012 Beltsville, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD Gist Ave., Silver Spring, MD 20910 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final €nysician/ disease or condition resulting in death) protton Medical Due to (as a consequence of): Examiner plication Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-transit that initiated events araverit resulting in death) Last Due to (or as a consequence of): Physician/Medical 0 Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ e Dementin Records, Completed 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes of Vital 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☐ Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 💢 No 12012 2 Accident 0 900 AM Investigation tell out of bed Suicide 6 Could not be 28e. Place o Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined MD City or Town, State) Montgone Assisted SUNVISE ASSISTED LIVING 19310 Club House RA

Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Descripting Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31391 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abultaraa 604 South Frederic Avenue 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ le+ Month 1225 21/16M 2012 Medical a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A more PI If Under 24 Hrs. Hours Min. 8 Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Months Days 219-18-0202 **Director** 1 **X** M 2 \square F 89 10/31/1922 MD Usual Residence of Deced 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location Examiner must be notified at Director **BALTIMORE** BALTIMORE MD 1 Yes 2 X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral USA 21209 2403 HUNT DRIVE death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 X Widowed 4 Divorced Completed injury or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) **AUTOMOBILES** PROPRIETOR 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FRIEMAN ROSE **PETERSON** ISADORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 SUGARVALE WAY LUTHERVILLE, MD 21093 SUĞARVALE WAY RICHARD PETERSON/SON 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Partment of Partment: If ite 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM. 10/14/2012 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Sign, ture o Funeral Service Ligensee any 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami ad The law requires that the death certificate be executed burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 nding physiuse as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes မ Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28b. Time of s after death.

I Director: After the ord in by the funera Certificate: Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 5 Pending 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) on 24 house the Funeral Direction of the filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 1012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Or BARA NIKITA 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar 16

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33143 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT 009 Year **Physician** 2012 MARY Ε. POWELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE LEVINDALE NURSING HOME 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1□ M 2X F Davs Hours Min 88 219-18-8594 Director PENNSYLVANIA NOV. 11 1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2X No BALTIMORE MARYLAND BALTIMORE CO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21207 3413 REDMAN RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX of Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXVo Specify. Specify: BLACK à 3 ☐ Widowed 4 ☐ XDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) SINAI HOSPITAL ER CLERK 12yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY BOURNE JOHN HOLMES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3413 Redman Rd., Baltimore, Md., 21207 Sarah Holmes/Sister-In-Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY 10-18-12 TIMONIUM, MARYLAND 21. Signature of Fine ral Fervice Licensee 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a plantic wants of death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent prognant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 pron 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9□Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No perform certificate or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death, within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be detempined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examîner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only

State Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

Division or Vital Records,

29b. Signature and title of certifier

30. Name and address of person who

Year)

Thomas 31. Date filed (Month, Day,

ORIGINAL

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month 1200PM Physician/ Medical 4c. County of Death
Anne Arundel 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Linthicum Tate Hospice House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year Days Hours Months 78 June 22, 1934 Massachusetts 014-28-1949 1 🗆 M 2 🔀 F Director 10d. Inside City Limits 10c. City, Town or Location 28a-f show 10b. County 10a. State at Completed by Funeral Director Gambrills 1 ☐ Yes 2X No Anne Arundel must be notified MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 21054 2607 Chapel Lake Drive #313 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. ıral", or iten Examiner n Black, White, etc. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify. Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced "natural", Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) h and Mental Hygiene. 7 is marked other than "r traumatic event, <u>the Med</u> College (1-4 or 5+) Elementary/Secondary (0-12) Real Estate Agent permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>til</u> once. Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Corea Turner ျ Ivan Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) 2607 Chapel Lake Dr. #313 Gambrills, MD 21054 Wayne Rinick/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 10/13/12 20a. Method of Disposition 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) Signature Funeral Service Licer P.O. Box 784 Going Home Cremation Service Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. small Immediate Cause (Final Man Ancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, is 26. Place of Death (Check only one) 25 Was case referred to medical Division of Vital Be Hopice House 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 1 Yes မ 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide Could not be 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) Signature applittle of certifi e and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Annapolis, MA

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State Registrar 1 6

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#2perPHYS.G932,10/18/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 33145 Certificate of Death Reg. No. 2. Date of Death Month 13 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2<u>012</u> Physician/ 13:40PM Reed Mary Ann Oct Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) **Funeral** Days Hours 47 218-84-4522 1 🗆 M 2 🕮 F Director 7-23-1965 MD Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a. State should be filed within 72 hours after death with the Maryland Director Taneytown Carroll 1 Yes 2 XNo MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21787 Funeral 3871 Fringer Rd. USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12, Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white If Yes, Give Completed 3 Widowed 4 K Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Tea Room Business Owner 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) item 27 is marked o Barbara Nelson Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl
Department of Health a
Important: If item 27 is
any injury or other tra 3871 Fringer Rd., Taneytown, MD 21787 Rotha Garland-son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 10/18/12 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilityFletcher Funeral & Cremation 21. Signature of Juneral Service License D. Main St., Westminster, MD 21157 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Jiving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause and ach line. Interval Between Onset and Death Immediate Cause (Final MK Physician/ T disease or condition resulting in death) Medical Examiner C Sequentially list conditions. rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examir that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Box 68760 the phy g guipt SE IF FEMALE ise s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month ō Pregnant at time of death 1 Yes 2 l 9 🗌 Unknown the P.0. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | ş 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s performed 2 No 1 TYes 26. Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 🗆 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After iniury work? Natural
Accident
Suite 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 29d. Date signed (Month, Day, Year) title of certifie 29b. Signature State Registrar

Amend 23a.pt.Ib.,25,per me,g937 3-1-13 sm
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #1,23a,Pt II per med cert G934 12/5/12 dk
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 201^{Ygar} 4:50 PM Hoover Rupert Lynn Hoover Rupert Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Gaithersburg Wilson Health Care Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 3 Day, Year 17 Months Days Hours 1 😾 M 2 🗆 F New Jersey 94 512-03-2877 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location items 23a or 28a-f sho her must be notified at Director 1 Yes 2 No Gaithersburg Montgomery MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 Funeral 333 Russell Avenue #621 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc o. Completed by 1 Never Married 2 Married within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White "natural", 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72... h and Mental Hygiene.
7 is marked other than "r College (1-4 or 5+) Elementary/Seconday (0-12) religion 12 clergy Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hazel Leona Linabary Lynn Hoover Rupert Page 1 and 2 should nent of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Gode) 206 Central Ave; Gaithersburg, MD 2087/ Elizabeth Wright - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service 22. Name and Address of Facility State Anatomy Board Ronald irector 21201 655 W. Baltimore St; Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final Physician/ debility disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner months subarachnoid hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events MEDICAL EXAMINER Examiner and I-transit that the death certificate be executed fall and anticoagulation ON APPROVE Due to (or as a consequence of) resulting in death) Last CERTIFICAT physician a Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Yes 2 No ed by the a detached f 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 has 2 No this certificate 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 1 X Yes →2 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License numbe 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 2012 pleted cause of death (Item 23a) (Type, Print) olinsta MO teven

State

Registrar

31. Date filed (Month, Day, Year)

16

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Jack

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	aryland / Dep	partment of Healt	h and Mental H	lygiene 201	2 33147
		77	Registrar 1. Decedent's Name (First, Middle.	Last)	Ce	rtificate of Deati	2. Date of	Reg. No.	
	nysicia Medio		William Robins	son			Month	Day Ye	
March Co.	xamin		4a. Facility Name (if not institution,			4b. City, Town, or Location		4c. County of E	
			820 S. Caton A			Baltimor			
	ineral ector		5. Social Security Number 218–40–9607	5. Sex 7. Age 1 X M 2 □ F	(In yrs. last birthday)	If Under 1 Year If Under 1 Months Days Hour	der 24 Hrs. 8. Date of I s Min. (Month,	Birth 9. Day, Year)	Birthplace (State or Foreign Country)
	سوي		Usual Residence of Decedent	1 18.5 101 2 2 1	70 Yrs.		Mar	15, 1942 M	aryland
ryland	-f sho led at	ctor	10a. State 10b. County		10c. City, Town or Lo	ocation			10d. Inside City Limits
e Ma	or 28a notif	Director	MD 10e, Street and Number		Baltim	10f. Zip Code		Tan Tani	1 Yes 2 No
with t	23a (Funeral	820 S. Caton Av	enue #3N		212	29	10g. Citizen of What	: Country?
death	items ner m		11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mexi-	Origin? (Specify Yes or N	0- 14. Race - A	merican Indian,
36 after	xamir	d by	1X Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	No	1 ☐ Yes 2 ▼ No Spec		Black, W Specify:	hite, etc.
hours	ical E	Completed	15. Decedent			dent's Usual Occupation	unk		
215 iin 72 ie.	nan "r Med	omp	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4 or 5+	(Give	kind of work done during m OO NOT use retired)	nost of working	Tob. Kind of Busine	ss/industry unk
d with	nt, the	Be C	unk	unk					
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.	c eve	To E	17. Father's Name (First, Middle, La Wilson Robinson	,			other's Name (First, Middle Agnes Porte		
ary hould ind Me	s mar umati		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street and Nun			Zin Code)
, National Action	n 2/ ii er tra		Annette Weaver/	niece	50	02 S. Pulaski	Street Bal	timore, MD	21223
			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date	20c. Location - City	or Town, State
Baltimore, permit. Page 1 and Department of Heal	njury		4 Donation 5 Donation Char	ecify) in state					
Depril	any		21. Signatury of Funeral Sevice Lice Lice Remail of S	vale, Dire	etor S	2 Name and Address of Fac tate Anatomy altimore, MD	Board 655 W 21201	. Baltimor	e Street
			23a. Part 1. Enter the disease, or c shock, of heart failure, List on	omplications that caused to				arrest,	Approximate
Physi			Immediate Cause (Final disease or condition		a cav	ncer			Interval Between Onset and Death
	dical niner		resulting in death)	Due to (or as	nsequence of):				191 5 1101
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):				
cuted	ransit	tami	cause. Enter Underlying Cause (Disease or Injury that initiated events	C					
e exec	the burial-transit	dical Examine	resulting in death) Last	Due to (or as a	consequence of):			·	
cate b	s the t			d				· · · · · · · · · · · · · · · · · · ·	
certifica	nse a	J.W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		7		23d. Date of	delivery
Geath of the atter	should be detached for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 4 Pregnant at t 9 Unknown		Ectopic pregnancy Other (specify)		Month	Day Year
at the	detach		Part II. Other significant conditions		not resulting in the u	Inderlying cause given in Pa	urt I. 23e Did	tobacco use contribute	to the squee of death?
Jires th	ld be	Completed by	Diabetes	Mellitus				_	Probably 4 Unknown
THE law requires ate has been significants.	2 shou	plete					24a. Wa:	s an 24b. Were	autopsy findings available
Sician: The law a	page	E O					per	formed? death	o completion of cause of ? /es 2 MNo
VILAI /sician: s certific	ector	Be	25. Was case referred to medical examiner?	Hospital:			eath (Check only one)		2 2 110
GIVI g Physi er this c	=	<u>۵</u>	1 Yes 2 Yo	1 ☐ Inpatien 28a. Date of injury	t 2 ER/Outpatier		Nursing Home 5 Res	1-1-1-	ecify)
nding ath. : After	e fune	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigat	(Month, Day, Y		28c. Injury at work? M 1 Yes 2	_	how injury occurred	
r Attendir ter death. rector: Af	by th	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be	- At home, farm, stre	eet, factory, office		(Street and Number or F	Rural Route Number,
oital o	filled ir							wn, State)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and	oletely	Medical	(Check 2 L Medical Exa	.miner: On the basis of exai	mination and/or invest	occurred at the time, date ar tigation, in my opinion, death death occurred at the time, o	occurred at the time, date	and place, and due to the	e cause(s) and manner stated
To th To th	сошр	— г	29b. Signature and title of certifier	1 - 1 - 0 - 1	A 40	29c. License number		29d. Date signed (Mor	
			darange 1	pungada	2 (4)	D5902	27	10-4-	2012
			30. Name and address of person wh	andda an	1 Caton	Are Ralt	inox, N	10 212	29
Po	State	7	1. Date filed (Month, Day, Year)	32 Registrar's	s Signature				
Re	gistra		OCT 1 6 2	112 Jeneur	A. gar	Kal			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ε. Rothenbach Virginia P M Medical 2:15 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore North Point North Point FutureCare Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours 217-38-2754 Director 1 🗆 M 2 💢 F 73 Dec. 7,1938 Maryland Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7827 Lockwood Road United States death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 9 Years Homemaker marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F 2 Goldie V. Outten Vernon E. Wallace 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7827 Lockwood Road Dundalk, Maryland Mr. Raymond J. Rothenbach Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) akeview Mem. Park Cem.10/17/2012 Sykesville, MD Fisher 2. Name and Address of Facility all Home of Dundalk, Inc. Obarl 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Phui ian disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events Exami attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? Yes 2 No certificate 2 🗌 No 1 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Director: After t d in by the funera Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending (Month, Day, Year) death. Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) hin 24 hours aft t**he Funeral Di** npletely filled ir Medical 29a. Certifie ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. heck dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 nly one) certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sanature and titl 0070BER 15,2012 00060560 30. Name and address of person who completed ca e of death (Item 23a) (Type, Print) STEMMERS AUN ROS

State Registrar iled (Month, Day

Amend #2 & 3 per MD g932 10/16/12 TRT

For State of Maryland / Department of Health and Mental Hygiene 20 12 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month RICHARDS October 5, M 1551 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospital Center Westminster Carroll Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min Hours 202-22-9084 1 □ M 2**X** F **Director** 83 Yrs. May 23, 1929 PA Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD Burke Springfield 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 5216 Grantham Street 22151 USA items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ò 1 Never Married 2 Married ģ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White "natural", Specify: 3 ¥ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 12 Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edwin James Masterson Anna Eiselin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Mark E. Richards (son) 6955 Eden Mill Road Woodbine, MD 21797 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State All County Cremation 10/9/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Signature of Funeral Service Licensee Tuy 1400764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death .Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atte in the past 12 months? Month Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an page 2 autopsy performed? Yes 2 No 1 🗌 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Tes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 10/8/2012 verily hu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMORS WES MINSTER MALVILLE & GHIVIN Til AVENUE STONEX 295 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Ontober 2012 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Johns Hopkins Bayview Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 99 220-24-4383 March 1, 1913 West Virginia Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a State 10b. County 1 ☐ Yes 2 😿 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō "natural", or Items 23a o dical Examiner must be 21222 United States Funeral 413 Stefan Court 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify Specify þ 3 Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than the Homemaker Own Home 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Laura Blossom William Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland Alcie O. Rappold (Daughter) 413 Stefan Court nt of Health a : If item 27 Is or other train Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite 1 X Burial 2 Cremation 3 Removal from State 10/18/2012 Oak Lawn Cemetery Baltimore, Maryland injury o 4 ☐ Donation 5 ☐ Other (Specify) Michael Neiser 2 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. any in once. Julia 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to or as a consequence of) disease or condition resulting in death) /Medical Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed -tran and Due to (or as a consequence of): burial-Box 68760, attending physiciar Physician/Medical the 98 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 Yes 2 🗷 No 26. Place of Death (Check only one) Physician: the funeral director, 25. Was case referred to medical Be examiner?

1 Yes 2 YNo Hospital: 1 X Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 3 DOA 2 ER/Outpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: l or Atter ding F after death. After 5 Pending investigation To the Hospital or Aux...
within 24 hours after death.
To the Funeral Director Afte 1 🔀 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the cause (s) and manner as stated.

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(check only one)

29b. Signature and title of certified

30. Nam and address of person who completed cause of death (Item 23a) (Type, Print)

satos

Gali

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

2tober 13,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10/11/2012 Teresa I. Russell 1:30 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) 3 / 4 / 1 9 5 9 Days Hours Min. Director 218-80-2362 1 M 2 X F 53 MD 28a-f show 10a, State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🕱 No Rosedal MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2036 Flintshire Rd. Apt. 302 21237 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married \$ Maryland 21215-0036 Black 1 ☐ Yes 2 🗖 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dialysis Tech. 12th Hospital Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Russell Virginia Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2036 Flintshire Rd. Victor Fuqua- Son Apt. 302 Rosedale, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 💢 Burial 2 🗌 Cremation 3 🔲 Removal from State Zion Cemetery Mt. 10/15/2012 Lansdown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Furieral Service Licensee March F/H-East 22. Name and Address of Facility North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Tue to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ou 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital: 1 ☐ Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Native Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature an ttle of certifier 10-11-12 son who completed cause of death (Item 23a) (Type, Print) (Hower, MO 21201 0 32. Registrar State 1 6 2012

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Oct 12, 2012 Vernon Edward Russell 3:30 A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Towson **Baltimore** Gilchrist Hospice Center 5. Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Oct 8, 1928 Director 216-24-3734 84 1√2 M 2 □ F show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🕅 No **Baltimore** Gwynn Oak 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5509 Gwynndale Rd. 21207 U.S.A 12. Was Decedent Ever in U.S.
Armed Forces?

1. Yes 2 No 9/30/1946
If Yes, Give 9/30/1949 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🗷 No Specify. White Specify: Completed 3 X Widowed 4 ☐ Divorced 9/30/1949 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Route Salesman Delivery 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Cora Balderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Russell PO Box 12 Glyndon, MD 21071 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date injury or (1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) **Good Shepherd Cemetery** Oct 17, 2012 Ellicott City, MD Siphature of Funeral Service 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Licer 23a. Part 1 Ent if the dise see a complications that cause shock, if eart failure. List only one cause on each line. or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir The law requires that the death certificate be executed physician and s the burial-transi Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Day after death.

Director: After this certificate has been signed by the a d in by the funeral director, page 2 should be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy I ☐ Yes 2 No Physician: Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital or A within 24 hours after To the Funeral Directory filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certil 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated pertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated rieck Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. nly one 29b. S gnatur nd title 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar PShaheen,

31. Date filed (Month, Day, Year)

6701 N. Cheeles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Schwartz Younk 2012 act Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Jan 1, 1942 New York Director 080-34-6726 1 ★ M 2 □ F 70 Usual Residence of Decedent 23a or 28a-f show 10c, City, Town or Location Montgomery Damascus 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 20872 25000 Applecross Terrace 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 24 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify なれて If Yes, Give 3 Divorced Specify:White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Window Cleaning Owner Schwartz 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Celia Kollinger Morris Schwartz injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 25000 Applecross Terrace Damascus, MiD 20872 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Joan S. Schwartz/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State cemetery, crematory or other place) Final Journey Crematory 10/15/12 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral/Service Lice Giller Holles Remation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Cardieralmona Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the a 2 No 9 Unknown P.O. | Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, been si 24a. Was an this certificate has ral director, page 2 autopsy performed? **Division of Vital** the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 FR/Outpatient 3 I DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural Accident 5 \square Pending Investigation within 24 hours after decented to the Funeral Director completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number

Approximate Interval Between Onset and Death minutes 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28f. Location (Street and Number or Rural Route Number, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10068207 Octiser 11,2012 1901 Medical Center Dine Rockille 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kella IVUL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 6 2012 Registrar DHMH 17 Rev 06-2011 ORIGINAL

3. Time of Death

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10d. Inside City Limits 1 Tes 2X No

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2				Registrar		Certificate of D	Death	Reg	. No. 2	2 33 154
5/2		Physicia Medic		1. Dejedent's Name (First, Middle, Last) Larles Alexande	er Shepp	ard		2 Date of Death October	13, 2012	3. Time of Death 5:20 P M
	0	Examir	ner	42 Macility Name (if not institution, give street and r Senes is Health Co	number)	Cator	Sville		4c. County of Dea	more
7		Funeral Director		5. Social Security Number 6. Sex 1.746 1.7 M 2.	F 93 Y	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir Co	thplace (State or Foreign ountry)
0-13-		yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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छ	9800	after dea il", or itei xaminer	þ	1 Never Married 2 Married 1 Yes,	Forces? es 2 □ No Give	If Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whit	
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F	21215	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed (Specify only highest grade completed (Specify only 12) College (Specify only 12)	ed) e (1-4 or 5+)	Give kind of work done of ife. DO NOT use retired)		I	3+0 R	ailroad
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<u>_</u>	altimore	. Page tment c tant: If jury or		1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify)	Arbut	us Memori	al 1019	7/12 /A	proutus	MD
Cher	Ball	permit. Page Department (Important: II any injury or once.		21. Signature of Funoral Service License	204	22. Name and Addles	ss of Facility G	reene	reneral	Services
5				23a. Part 1. Enter the disease, or complications th shock, or heart failure. List only one cause or	at caused the death. Do no	ot enter the mode of dying	g, such as cardiac	or respiratory arrest,	Car.	Approximate Interval Between
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	Box 6	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physic feed filled in by the funeral director, page 2 should be detached for use as the batten filled in by the funeral director, page 2.	Physician/Medic	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy ive Birth 2 Fetal death regnant at time of death Inknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	ру		23d. Date of de Month	elivery Day Year
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	Division of Vital Records,	rsician: The law re s certificate has be lirector, page 2 sh	Completed by	Azheimers Demoi	stca U			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
	E	cian: T ertifica ector, p	Bec	25. Was case referred to medical examiner?			lace of Death (Chec.			
	Ţ	Physic this or	ြို	1 L Yes 2 KNo	☐ Inpatient 2 ☐ ER/Out ate of injury 28b. Ti		4 X Nursing Ho	ome 5 Residence 28d. Describe how	be 6 Other (Spe	cify)
	o uc	nding ath. r: After e fune	icate	1 Natural 5 ☐ Pending (A 2 ☐ AccidentInvestigation		jury work		250. 50001150 11011	injury obouriou	
	Division	To the Hospital or Attending Physician: Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:		ace of Injury - At home, farmulating, etc. (Specify)	m, street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
	_	e Hospitt 24 hour e Funera bleted fille	Medical	29a. Certifier 1 M Certifying Physician: To the (Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Praction	basis of examination and/or	investigation, in my opinio	on, death occurred a	t the time, date and p	place, and due to the	cause(s) and manner stated.
		To the within 2 To the comple	_							
		10		29b. Signature and title of certifier Alltra	cause of death (Item 23a) (T	olling Feon	Rd, Suite	44 , Pace	etmore of	4021227
		Sta	ate	31. Date filed (Month, Day, Year) 33.	2. Registrar's Signature	are	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State Registrar		State of N	Marylan		artment of H <i>tificate of D</i>			giene _{Reg. No.} 2 (112	33155
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Examir	ier	Univ. of M				enter		more		40. 000111	N/A	
Funeral Director		5. Social Security Number 225-02-5983	6. Sex	7. A	Age (In yrs. Ia	**	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)	Coun	
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th with ms 23smust l	Funeral Director	5043 Branch		Road 2. Was Deceder	ot From in 116	2 112 1	Vas Decedent of His	20740	acify Vac or Na-		ted S	
Iryland 21215-0036 ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ρ	11. Marital Status1 □ Never Married 2 □3 □ Widowed 4 ▼ Di	☐ Married	Armed Forces 1 Yes 2 If Yes, Give Year or Dates	§? X INo	l	Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)		ce - Americ ck, White, o : Whi	etc.
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hyglene. 27 is marked other than "natural", o traumatic event, the Medical Exam	To Be	17. Father's Name (First, Manager David O. Sor						18. Mother's Nam Dorothy			ie)	
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Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other		21. Signature of Funeral Se		Alyson		or 22		s of FacilityCrer	mation 3 , Baltin	Society more, Ma	of Ma aryla	aryland Inc nd 21228
		23a. Part 1. Enter the dise shock, or heart failure Immediate Cause (Final	ase, or complice. List only one	cations that caus cause on each	sed the deat line.	h. Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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Box 68760 death certificate be execute the attending physician and ed for use as the burial-tran	an/M	IF FEMALE: 23b. Was decedent pregna	.rit	Bc. If yes, outcor			Ectopic pregnanc	·v		23d. D	ate of delive	
ords, P.O. Box 68.7 requires that the death certific been signed by the attending should be detached for use as	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	7	4 Pregnan 9 Unknow	nt at time of o		Other (specify)	, , , ,		M	onth	Day Year
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Physical this ceral direction	e: To	1 Yes 2 No 27. Manner of Death		1 🔀 Inp	njury	ER/Outpatier 28b. Time of	28c. Injury	4 ∐ Nursing H ⁄ at	ome 5 Residence Residence Residence Section Residence Re	dence 6 Ott)
on (ending eath. or: Afte the fun	Certificate:	2 Accident	Pending Investigation	(Month, i	Day, Year)	injury	M 1 🗆	? Yes 2 \(\sum \text{No} \)				
Division of Vital tal or Attending Physician: rs after death. al Director: After this certific ted in by the funeral director.	Certi	3 ∐ Suicide 6 ∐ 4 ☐ Homicide	Could not be determined	28e. Place of building,	Injury - At ho etc. <i>(Specify</i>	ome, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Numi vn, State)	per or Rural	Route Number,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check 2 Me	dical Examine	er: On the basis of	of examination	n and/or inves	occurred at the time tigation, in my opinio , death occurred at ti	on, death occurred a	at the time, date a	and place, and d	ue to the ca	use(s) and manner stated.
To th∉ within To th€ compl	2	29b. Signature and title of		/A 40 0	. 310 2001 011	,omeage	29c. License	number		29d. Date sign		
		30. Name and address of p	nerson Occasion	mpleted cause of	SMI death (Item	23a) (Tune 1		88191281	υφ	10/13	112	
.,		22 S. Gre	eene s	it. Ba	timo	re N	10 2120	1 M	eng W	ang.		
Sta Registr		31. Date filed (Month, Day,			strar's Signa	d. A	all	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cathryn M. Sutley Swann 9:00 P.M October 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore County** Blakehurst Retirement Community Towson . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours 218-46-3682 95 **Director** 1 □ M 2 🏝 F Aug. 20, 1917 Baltimore, MD. Usual Residence of Deceder 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director notified Baltimore County Maryland Towson 1 Yes 2 No 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be United States 23a Funeral 1055 W. Joppa Road 21204 items 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Specify. Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Home Maker 03 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Hughes McKay Maybelle LaRue Reynard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs.Sandra S. Kull (Daughter) Cockeysville, Maryland 21030 34 Iron Mill Garth 20a. Method of Disposition 20b. Place of Disposition (Name of Date (Harford County) Ewans Fune al Crapel and Cranal ion Services, Inc. Sunday, Oct. 14, 2012 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland se of Funeral Service Licensee Jeffrey I. Gair, Sc. G. P. Name and Address of Facility es Funeral and Cremation Center, P.A.

Recetul Alternatives Funeral and Cremation Center, P.A.

21093-2215 21. Signat 2325 York Road Timonium, Maryland 23a. Furt 1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ cerebrovassular accident disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine rany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): and I-transit that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as i ed by the attending I IF FEMALE. asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ģ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Unknown g 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕻 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 No this certificate 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After iniury work 1 🕰 Natural 5 Pending ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu 1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Naron M. Kein, CRNP

1 6 2012

1055 W. JOPPA ROAD

towson, mb 2/204

R04840

10/12/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Salamone Shirley Μ. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death 5109 Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 1 M 2 X F Hours Country) Director 84 20-18-8400 28. 1928 New Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Harford Abingdon 10e. Street and Numbe 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 325 Regal Drive 21009 United States and Mental Hygiene. is marked other than "natural", or items 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ð Yes 2 No 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Data Processor Financial Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Llewlyn R. Metz Mabel B. Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 Abingdon, Maryland Joseph Salamone (Son) 325 Regal Drive other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/15/2012 Donation 5 Other (Specify) Holy Redeemer Cem. Baltimore, Maryland Most of Funeral Service License Dennis Signatu carroll Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause out, at lin. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine and -transit Cause (Disease or linjury that initiated events resulting in death) Last the burial-Physician/Medical igned by the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de 1. Completed by 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available Hospital or Attending Physician: The law autopsy prior to completion death? 1 Yes 25. Was case referre Division of Vital Be to medical 26. Place of Death (Check only one) 21 No. Other 2 1 Year 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 🛚 Naturat work?
1 Yes 2 No 5 Pending injury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Sigr 29c. License number 29d. Date stoned (Month. Day, Year) 10 Name and address of person who completed callse of death (Item 23a) (Type, Print) W Date filed (Month-Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Merril Elza Scarborough October 0 6:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4328 Conowingo Road Harford Darlington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 220-22-0518 Director 1 🕅 M 2 🗆 F Yrs. 92 6, 1920 Maryland Oct. Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or than "naturel", or items 23e or 28a-f sho within 72 hours after death with the Maryland Director 1 ☐ Yes 2 X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 4328 Conowingo Road 21034 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Ś Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", any injury or other treumatic event, the Medical Exar If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Civil Service Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine (nmn) Few Hamilton Yingling Scarborough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Beall / Daughter <u>3736 Federal Lane, Abingdon, Maryland 21009</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State from Stat 1 X Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) Smith's Chapel Cem. 10-19-2012 Churchville, Maryland ture of Funeral S 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Sign 1317 Cokesbury Road, Abingdon, Maryland 21009 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHE 1000 disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopath Sequentially list conditions, Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): resulting in death) Last 24 hours after death. Fund this certificate has been signed by the attending physician. Funeral Director: After this certificate has been signed by the attending physician etely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24a. Was an 24b. Were autopsy findings available P Chronic Kidney disease Aremin prior to completion of cause of death? performed? 1 Yes 2 No Anasiera Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 🗌 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou To the Funer completely fil 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/15/12 D31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kloesz

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

sue

Kenwork

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32. Registrar's Sig ature

Baltonire

12-07690 Melissa Shea Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Melissa Shea		State of Maryla 1- For State Registrar		artment of rtificate of		and	Menta	l Hyg		eg. No. 2	0	2 3315
Physici Medical Exami		Decedent's Name (First, Middle,Last)							Date of Deat Month	Day Yea		3. Time of Death 2335 hrs
- LAGIII	IIICI	Melissa Ann Shea 4a. Facility Name (if not institution, give street and nu	ımber)		b. City, Toy	vn. or Lo	cation of [October 1	0, 2012 4c. County of	of Death	2333 1118
		2649 Dulany Street			Baltimo	re						
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		If Under		If Under 2			th (MM/DD/YYYY	9. Birtl Foreign	
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any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location	on							10d. Inside City Limits
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Aaryland 28a-f show	Director	10e. Street and Number			10f. Zip Co				10	0g. Citizen of Wh	at Coun	try?
15-0036 filed within 72 hours after death with the Maryland 1Hygiene. ed other than "natural", or items 23a or 28a-f sho t, the <u>Medical Examiner must he notified at once</u>		2649 Dulany Street			212	23				USA		
ath wit tems 2 st he 1	Funeral	11. Marital Status 1 X Never Married 2 Married Armed F			Decedent of Specify Control				ify Yes or No- can, etc.)	14. Race White		an Indian, Black,
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Richard St. Pierre								haine		
MD 212 2 should be h and Menta 27 is marke	7	19a. Informant's Name/Relationship (Type, Print) Richard Shea brother								ber, City or Town		
D the H E		20a. Method of Disposition		Place of Disposit					Date	11, MA 20c. Location -		
Baltimore, permit. Pages 1 a Department of He (important: If ite injury or other ti		1 Burial 2 Cremation 3 Removal fr		rematory or other						Glen B		
Baltimo permit. Page Department o Importunt: injury or oth		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee								uneral	Se	rvice
inje Per 😡		RAMIN		1/22	?1 Gr	ayb'	urn	Dr	Glen	Burnie	MD	21061
Physician // // // // // // // // // // // // //		23a. Part I. Enter the disease, or complications that can failure. List only one cause on each line. Dro	aused the death. wning co	Do not enter the omplicat	e mode of d	ying, suc u I t i	n as card ple d	iac or re I rug	spiratory arre	st_shock, or head one,	rt	Approximate Interval Between Onset and
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certificate onding phy	an/	23b. Was decedent pregnant in the past 12 months?	irth	2 Feta	al death	3 🔲	Ectopic pr	egnancy	,	Month	Da	ay Year
Box 6876(he death certificate the attending physhed for use as the b	Physician/M	1 Yes 2 No 9 V Unknown 9 Unknown	ant at time of dea own	atri 5 Oth	er (Specify)							
~ ≠ ∞□		Part II. Other significant conditions contributing to	death but not re	sulting in the un	derlying ca	use give	n in Part I.		23e. Did tob	pacco use contrit	oute to th	ne cause of death?
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Vital ysician: his certifi director,	å	25. Was case referred to medical examiner?	npatient 2	ER/Outpatient		Place of I Oth	Death (Ch			Residence 6	Othor	Coope
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Division To the Hospital or Attendit within 24 hours after death. To the Foueral Director: A completely filled in by the fu		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the bes		use/Rowl				B	altimo:	re,MD.		
thin 24	ledical	one) 2 Medical Examiner: On the basis of	of examination ar							• •		
To wit	Me	29b. Signature and title of certifier	ateu.		29c. Li	cense nu	ımber			29d. Date signe	d (Mont	h, Day, Year)
		anile			0	.C.M.E	Ξ.			October 11,	2012	
()		30. Name and address of person who completed caus			A/ D=1+:	ore C	root C	n lêi en c		222		
7	ate		ledical Exam gistrar's Signatur		v. baitim	iole 91	ieet, Ba	allimol	re, MD 212	223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			State Registrar	Cer	tificate of Death		Reg.	No. 20	2 33 1 6 0
Phys	sicia	n/	1. Decedent's Name (First, Middle, Last) Betty Ann Slusarski				Date of Death Month	Day Year	3. Time of Death
	ledic amin		Betty Ann Slusarski 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location of	of Death	J Ctober	4c. County of De	
Exe	3111111	er	Citizens Nursing Hom		Lange De	Gene		Hacker	au
Fune	eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under Months Days Hours		Date of Birth	9, B	irthplace (State or Foreign ountry)
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and show	te	o		Oc. City, Town or Loc	ation	-			10d. Inside City Limits
Maryla 18a-f	tified	Director	Maryland Harford	Aber	deen				1 🗗 Yes 2 ☐ No
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th with	must	Funeral	328 Mt. Royal Avenue		21001			USZ	
or ite	niner	by Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Everores? 1 □ Yes 2★No.	If	Vas Decedent of Hispanic Orig Yes, specify Cuban, Mexican	gin? (Specify 1, Puerto Rica	Yes or No- an, etc.)	14. Race - Am Black, Wh	
036 rs afte rral",	Exar	ed b	3 ☒☒/idowed 4 ☐ Divorced If Yes, Give Year or Dates.	1	Yes 2XXNo Specify:			Specify: W	nite
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Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural" o	ent, t	Be (17. Father's Name (First, Middle, Last)			er's Name <i>(Fil</i>	rst, Middle, Maid		,
/lan	tic ev	은	Peter Klopotek		Cla	ara P	rodz		
lan,	anma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and Numbe	er or Rural Ro	oute Number, City	or Town, State, 2	(ip Code)
and 2 realth	her tr		Diane B. Bechtol (executor)		Battersea La				2309
ge 1 gr Hite	or of		20a. Method of Disposition 1 ☐ Burial 2 ★★ remation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem	natory or other place)	Date		Location - City of Chest	
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filed in by the intend investor page 2 should be detached for use as the build-transit		dical	d						-
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Jan Witter	3		29b. Signature and title of certifier		29c. License number	42	29d.	Date signed (Mon	th, Day, Year)
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(eV			30 Name and address of person who completed cause of dea	Signature	Tame (1)	15	mp	21078	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 Year 2012 A^{M} Michael R. Schafer 12:45 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Center Towson Baltimore **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Country) Maryland Months Hours Min. (Month, Day, Year) 07/18/1967 1 M 2 □ F Director 215-02-3935 45 Yrs. show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1704 Yakona Road 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify. Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Handyman 12 Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 Is marke any injury or other traumatic Harry J. Schafer, Jr. or other traumatic Eva Mathewson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michele Gallagher / Sister 4305 Northcliff Road, Glen Arm, MD 21057 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/12/2012 Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Borota Marshalk Dougla W. Warshall Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cruse on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown 9 Unknown Part Lather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? 2 No Hospital Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Cother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work?
1 Yes 2 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Medical Extring Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Extring Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one of certifie person who completed cause of death (Item 23a) (Type, Print) (07-01 N. (1) State

Registrar

Box 68760

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of De Physician/ October ľ³. 20 Î 2 Sanchez Charlotte 3:45 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Min (Month, Day, Year) 421-28-3241 Director 1 🗆 M 2 🛛 F May 23, 1924 Alabama Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 ☐ No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Booth Street 20878 United States 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other to any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Flynt Pansy Stroup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15408 Quail Run Drive, Gaithersburg, Maryland 20878 Susan Levin / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls Cemetery October 17, 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 Signature of Fune of Service Licensee Robert A. Fumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850—2805 M01305 23a. Part 1. Onter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OPD Physician/ exacerbation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) To the Hospital or Attending Physician: The law requires unat one within 24 hours. Her death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 📈 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) ၉ 1 Tes 2 📈 No 1 Nanatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 000064068 20/2 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Rockville. MO 9901 Medical Center alaria 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State

Registrar

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Sanchez

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State of Maryland / Department of Health and Mental Hygiene O. 1. 0.

			For State Registrar	State of Ma	ryland		rtment of I tificate of I		and IV	lental Hy	/giene Reg. No	(m)) 2	33163
	Physicia		Decedent's Name (First, Middle, Lass Ma:	rjorie Mae	e Sp	ratt				2. Date of Do			Ž012	3. Time of Death 12:16 PM
1	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Town, c					. County	of Death	
	Funeral		Holy Cross Hospi 5. Social Security Number 6. Se		(In yrs. last	t birthday)	If Under 1 Year Months Days	er Sp: If Under Hours		8. Date of Bi		поп	9. Birthpl Counti	ace (State or Foreign
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baitimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	Mont Crem	ce of Dispos netery crem gomer latori	ition (Name of atory or other pla um, Inc.	ce)	0cto 201	ber 14, 2	1		City or Tov	vn, State aryland
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10 01	th.: After this function of the function of th		27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	28	8b. Time of injury	28c. Injur worl	y at	2	28d. Describe				
TO HOISINIO	al or Atter s after des I Director d in by th	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			e, farm, stre	et, factory, office			28f. Location (City or To			er or Rural F	Route Number,
- , -	n 24 hours n 24 hours ne Funera oletely fille	Medical	(Check 2 Medical Exami	sician: To the best of mer: On the basis of exa se Practitioner: To the	amination a	ind/or investi	gation, in my opini	on, death oc	ccurred at	the time, date	and place	e, and due	e to the caus	se(s) and manner stated.
	withi To th		29b. Signature and title of certifier			1	29c. Licens		-		29d. Da	ite signed	d (Month, D	
	12		30. Name and address of person who o	completed cause of dea	ath (Item 23		int)						-L 14;	, 2012
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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Tate Hospice House Linthicum 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Country)
Indiana Days Hours Min Director 310-38-0481 75 1 □ M 2 🛣 F July 16, 1937 Usual Residence of Decede or 28a-f show filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Columbia <u>Howard</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21045 USA 7080 Cradlerock Way #305 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 ☐ Yes 21 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify. Specify: White 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Alcohol/Drug Addiction Counselor Healthcare permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic æ other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elmer Luttrell Ethel Slavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Allerford Drive Hanover, MD 21076 Patricia Ann Paetow/daughter 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Final Journey Crematory 10/16/12 4 Donation 5 Other (Specify) Woodbine, MD Signatur of Funeral Service 22. Name and Address of Facility. Sing Home Cremation Service P.O. Box 784 M01251 MD 21029 Heckrotte, P.A. _Clarksville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ars Medical Due to for as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 → No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a Id be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by this certificate has been signal that director, page 2 should? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 🗆 Yes 2 🗆 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital TATE 의 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 28a. Date of injury (Month, Day, Year) DSPICE 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending H 0V5E 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav) Year) 15 12 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EVA 巨 RSH 31. Date filed (Month, Day, Year) 32, Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month : 45 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WSOn more If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) Months Days Hours Min. **Director** 1 M 2 F Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentai Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Mamied 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ₩idowed 4 Divorced Year or Dates ack 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame ၉ 19a. Informant's Name/Relationship (Ape, Print) 19b. Mailing Address (Street and Number or Rural Moute Number, City or Town, State, Zil Code) 2194 Georg Rd ndsor Mill MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any Injury or o cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn 10 21. Sign thre of Funeral Service Lice Funeral Home, P.A: 21016 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a a consequence of): Examiner Costridion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 Day Pregnant at time of death P.O. Part II_Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No 2 N No Yes Division of Vital To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOS pure 1 🗌 Yes 2 🔯 No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work? 1 🗆 Yes 2 🗆 No injury Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tine of certifier 29c. License number 29d. Date signed (Month. Day. Year) *Forser* Lon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kes 31. Date filed (Month, Day, Yea gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0255 M 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 510 Munroe Circle Glen Burnie Anne Arundel Social Security Number **Funeral** 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Davs Hours 12/12/1923 **Director** 198-18-9061 1**X** M 2 □ F 88 Yrs Pennsylvania Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21061 510 Munroe Circle United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 1 Never Married 2 X Married Black, White, etc. 1 Yes If Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates nt of Health and Mental Hygiene.

If item 27 is marked other than "nature or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephan Toth Mary Grescovitch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence R. Esser/ Spouse 510 Munroe Circle, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 10/13/2012 Glen Burnie, Maryland Glen Haven Mem. Park 22. Name and Address of Facility Kirkley-Ruddick Funeral Home eral S 90 421 Crain Highway SE, Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between WONTH ! Immediate Cause (Final Physician/ URA MALIGNANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier who completed cause of death (Item 23a) NNAPOLIS MD ZIYUI

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carrie Lewis Tolliver 2012 Medical 10 20a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3204 North Hilton Street Baltimore If Under 1 Year If Under 24 Hrs. . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Director 288-22-3839 1 □ M 2 🗓 F 98 05 08 14 AL if Health end Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28a-f shov other traumetic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No NA Baltimore 10e, Street and Number 10g. Citizen of What Country? 3204 North Hilton Street 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 ☐ Yes 2 🟋 No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8th grade na Housewife House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file nend Mental H Richard Lewis Anna Jasper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health er Importent: If item 27 Is eny Injury or other trau James Tolliver-Son 3204 North Hilton Street, Baltimore, Md 21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🗌 Burial 🧏 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 10/16/12 Baltimore, Md 21. Simatur e_of Funeral Service Licensee March For H West 4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 18 u 188 Medical o or as consequence of): Due Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) ettending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) Year ed by the detached q 🗌 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who completed cause of de (Item 23a) (Type, Print) Month, Day, Year)
T 1 6 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 1 Nonth 13Day 20ĺ2 John Russell Teller 7:15a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Havre de Grace Harford Harford Memorial Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 098-34-8851 Min 4270971943 New York Director 1 M 2 □ F 68 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any righty or other traumatic event, the Medical Examingr must be notified any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 A Yes 2 No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21001 510 Ruby Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Military Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Russell Teller Barbara Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Teller 510 Ruby Drive, Aberdeen, MD 21001 (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State West Chester, 4 Donation 5 Other (Specify) R.A. Ferris & Company 10/15/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) vicanou Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other sig<mark>nificant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 힏 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After completely filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15/2012 10 Thosal MI 0006934 30. Name and address of person who completed cause of death (Item 23a) (Type

Registrar
DHMH 17 Rev 06-2011

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SOMAJITA GHOSAL.

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31. Date filed (Month, Day, Yea

MD: 103A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month/D 3. Time of Death Physician/ Day 813 AM ARON IAPIA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 6'len Burnie nne seunder Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Hours (Month, Day, Year) **Director** 214-56-2814 64 1 □ M 2 🗶 F Maryland 26, 1948 July 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1XXYes 2 ☐ No Maryland Baltimore 5 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? or items 23a Funeral within 72 hours after death with 21230 3021 Georgetown Road United States 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗡 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Yes, Give "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working je 1 and 2 should be filed within 72 t of Health and Mental Hygiene. If item 27 is marked other than ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Unk Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Mary Vivian Mitchell Albert Loetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3021 Georgetown Road, Baltimore, Maryland 21230 Michael A. Gusilatar/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Loudon Park Cemetery 1 XXBurial 2 Cremation 3 Removal from State Oct. 16, 2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licen 22. Name and Address of FacilityAMBROSE FUNERAL HOME OF LANSDOWNE MOHSE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that causes shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ARDIOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician Physician/Medical or Attending Physician: The law requires that the death certificate be $\#2l_0+ \#3$ Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery Ectopic pregnancy Por Month Pregnant at time of death Other (specify) Day Year g Unknown detac been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Tyes 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral (27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Investigation 6 Could not be Accident 24 hours after deal Funeral Director; Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

only one 29b. Signatur

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of person who completed cause of death (Item 23a) (Type, Print)

To the I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Marylan	nd / Depa	rtment of I	Health a	and Mental H	ygiene			
			State Registrar	Cert	tificate of I	Death		Reg. No. 2	012	_33	170
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8	Examin	er	4a. Facility Name (if not institution, give street, and number) Franklin Square Hispital	2	4b. City, Town, c	Ada (a	or Death		ty of Death	211/0	
	Funeral	77	5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		irth	9. Birthp	place (State or	Foreign
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1	s 23a nust b	Funeral Director	7617 Chesapeake Drive		2121	.9		Unite	d Stat	es	
<u> </u>	death item		11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of H Yes, specify Cub	lispanic Orig an, Mexican,	gin? (Specify Yes or No , Puerto Rican, etc.))- 14. R:	ace - Americ ack, White,		
16	after al", or xami	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 9 Year or Dates.	1	☐ Yes 2 🙀 No	Specify:		Speci		ite	
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Stature of Funeral Service Lice et ennis	/ 15	Name and Addre uda-Ruck 7922 Wis	ss of Facility Fune	ral Home o Dundalk,	f Dunda Maryla	1k, In	222	
			23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.							Approximate	
1	hy ician	05 A	Immediate Cause (Final disease or condition	nholus	in rial	ot are	1/18th oulm	unary ar	erv.	Onset and D	
	Medical Examiner		resulting in death) Due to (or as a consection)	quence of):	U		1		1		
8		e e	Sequentially list conditions, if any, leading to immediate b. Du lo (or as consec	Manuel offi	gnant 1	reopla	Sm				_
	ted nsit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.						1		
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09	ate be executed hysician and the burial-transit	dical	d		_	w				<u> </u>	
387	ertifica ling ph se as t	/Me	IF FEMALE: 23c. If yes, outcome of pregn	12 DCV							
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. P.O.	or Attending Physician: The law requires that the death certificate be executed after death. After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	by	Part II. Other significant conditions contributing to death but not re	sulting in the ur	nderlying cause gi	iven in Part I		tobacco use co			
rds	equire een si hould	Completed									
000	sician: The law r s certificate has b director, page 2 s	ldu					24a. Wa	opsy formed?	death?	osy findings av mpletion of ca	use of
E.	n: The la ificate ha		25. Was case referred to medical		26 P	lace of Deat	1 ☑ Yesth (Check only one)	3 2 □ No	1 Yes	2 No	
Vita	ysicia s cert direct	To Be	exam/ner? 1 Yes 2 No Hospital: 11 Inpatient 2	BR/Outpatient	_ Loth	or	rsina Home 5 🗆 Re	sidence 6 🗆 0	ther (Specify)	
of	ng Phi ter thi ineral		27. Marner of Death 1	28b. Time of injury	28c. Inju	ry at		how injury occu		,	
ion	tendii leath. Ior: Ai the fu	Certificate:	2 Accident Investigation		M 1	Yes 2 🗆					
Division of Vital Records,	l or At after d Direct I in by		4 Homicide determined 28e. Place of Injury - At P building, etc. (Speci	nome, farm, stre	et, factory, office			(Street and Nun own, State)	iber or Rural	Route Numbe	3 <i>1</i> ',
, Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination	on and/or investi	gation, in my opini	ion, death oc	curred at the time, date	and place, and	due to the ca	use(s) and man	ner stated.
	o the l	Me	only one) 3	my knowledge,	death occurred at		e and place, and due to	the cause(s) and			
	0 - 2 -		ANN			5000 2)		10 -		
	M		30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Pr	rint)				nina	7	
	Stat	e	31. Date (1) 4 orth, Pay Year) 32. Registrats Sign	atyfe	nal 12 fm	ure is	srive Bal	10., IV	HV) +	
	Registra		31. Date 15 Youth, Payyard 32. Registrarts Sign	Parket							

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			1 - State of Ma	aryland / Depa <i>Cer</i>	artment of H			iene eg. No. 2016	2 33171	
	Physicia		1. Decedent's Name (First, Middle, Last) LAVERT A. VIA				2. Date of Deat		3. Time of Death 10:10A M	
and the last	Medic Examin		4a. Facility Name (if not institution, give street and number)	-	4b. City, Town, or	Location of Death		4c. County of Death		
			MAPLES OF TOWSON			TOWSO	N	В	ALTO.	
	Funeral Director		219-20-7621 1 □ M 2 X F	(In yrs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth MAY 27,	1923 9. Bi	rthplace (State or Foreign ountry) TRGINIA	
рL	how	_	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits	
lanylaı	sa-f s ified	Director	MD. N/A		BALTIMORE	r II			1 ¥ Yes 2 □ No	
the N	or 28 e not		10e. Street and Number		10f. Zip Code		1	l 0g. Citizen of What C		
with	is 23a nust k	Funeral	4312 SPRINGWOOD AVENUE		21	206		USA		
15-0036 72 hours after death with the Maryland	r Health and Mental Hygjene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1	11	Vas Decedent of Hir f Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W		
21215-0036 within 72 hours after	ne. han "nat e Medica	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-1)	(Give H	lent's Usual Occupa kind of work done d O NOT use retired)		ing	16b. Kind of Business	s Industry	
d within	Hygier other t	ம	11TH	RIV	OTOR			GLENN L. M	ARTIN	
yland Id be filed	and Mental Fis marked or aumatic eve	70	17. Father's Name (First, Middle, Last) WILLIE F. VIA			18. Mother's Nam	e (First, Middle, M A. MORRI:	· · · · · · · · · · · · · · · · · · ·		
Man 12 shoul	alth and I		19a. Informant's Name/Relationship (Type, Print) MABEL A. VIA SI	19b. Mailin	g Address (Street a	and Number or Run BARRACKS	al Route Number,	City or Town, State, Z	ip Code) LLE,VA. 22901	
Baltimore, Maryland	Department of Health Important: If item 2: any injury or other tonce.		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Removal from State 4 → Donation 5 → Other (Specify)		sition (Name of natory or other place	e)		20c. Location - City o	r Town, State VIRGINIA	
Baltin permit. P	Departm mportar any injur ance.	İ	21. Signature of Funeral Service Licensee		. Name and Addres	s of Facility MI	LLER-DIP	PEL FUNERA	L HOME INC	
		\dashv	23a. Part 1. Enter the disease, or complications that caused	the death. Do not ente				MD. 21206		
	mician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	Stage (CHF	y, such as cardiac (or respiratory arres	st,	Approximate Interval Between Onset and Death	
	Medical aminer		Due to (or as a	consequen /e of):	\$15				Unknown	
pa	nsit	Examiner	Sequentially list conditions,	consequence of):						
e execut	ician and ourial-tra	dical Exa	that initiated events C.	consequence of):						
760	physi the k	edic	d							
Box 687 death certifica	within 24 from a tree locarit. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh 23c. If yes, outcome o 1 □ Live Birth 2 4 □ Pregnant at 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of de Month	elivery Day Year	
o hat the	ed by t detack	y Ph	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?	
ds, I	en sign	ted by	atrial Fibrillater	~·			1 □ Ye	s 2 No 3 I F	Probably 4 🗆 Unknown	
e law rec	s certificate has be lirector, page 2 sho	Completed					24a. Was an autops perform	y prior to death?	utopsy findings available completion of cause of	
ii m	tificat tor, pa		25. Was case referred to medical		26. Pla	ace of Death (Check	1 L Yes 2	No 1 ☐ Ye	s 2 🖎 No	
Vit	is cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatien	Otho			nce 6 Other (Spec	ASSISTED	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter clearh.	I Directo		3	y - At home, farm, stre (Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Ru State)	iral Route Number,	
The Hospit	he Funera	Medical	29a. Certifier 1 Certifying Physician: To the best of m (Check only one) 3 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Nurse Practioner: To the best of m (Check only one) 1 Certifying Physician: To the best of m (Check only one) 1 Certifying P	amination and/or investi	gation, in my opinior	n, death occurred a	the time, date and	place, and due to the	cause(s) and manner stated.	
J po te	To the		29b. Signature and title of certifier Outhory Ro	P	29c. License	number	29	Date signed (Mont	h, Day, Year)	
10	V		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type, Pr	rint) 7	Su Sun	san Ant	Hony CRA)P	
	Stat Registra	e	31. Date filed (Month, Day, Year) 2012 (32. Registrar)	ath (Item 23a) (Type, Prossing STET 4	W.		, ,,,,,	- 11-12	7	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2254 M RENE VANDERCOUK 2012 October ì١ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, **Funeral** 1 M 2X F Months Days Hours Min. 214-70-7595 August 20,1940 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits the Maryland 10a. State 10b. County 10c. City. Town or Location 1 Yes X No Baltimore Dundalk Director Maryland 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ō death with items 23a or ner must be r USA 21222 7300 Dunmanway Apt A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 XNo Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or itel
ury or other traumatic event, the Medical Examiner 1 Yes 2 if Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White Specify þ 3 Widowed 4 N Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Riverview Nursing Home Laundry Aid 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amelia Barr Nelson Eugene ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 817 Brunswick Road, Essex, Maryland 21221 Cassandra Guthrie Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 Burial 2 XCremation 3 Removal from State 18, 2012 Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licerse ^{22. Name and Address of Facility}
Connelly Funeral Home of Dundalk, P.A.
7110 Sollers Point Road, DUndalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ASCVD disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discouse of injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has director, page 2 performed Yes 2 2 🗌 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 1 X Yes 2 □ No 2X ER/Outpatient 3 □ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 🗌 Yes 2 □ No death. 2 Accident Director: A 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours af

To the Funeral Di

completely filled in Hospital 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

Emily

31. Date filed (Month, Day, Year)

5

WELL 0 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rlisle

32. Registrar's Signature

D0070999

October 11,2012

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ Medical 4c. County of Death **Examiner** 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs. **Funeral** Min (Month, Day, Year) 1 🗆 M 2 📆 F Director 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Id be filed within 72 hours after death with the Maryland Mental Hygiene. other traumatic event, the Medical Examiner must be notified at by Funeral Director 1 ¥ Yes 2 □ No 10g. Citizen of What Country? 15 or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced BLACK Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BALTIMORE COOK Be 17. Father's Name (First, Middle, Last) ပ SHOATS ZOIENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health as Important; If item 27 is any injury or other trau once, Md. 21218 BATTIMORE, 1565 NEPHEN 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory 1 Material 2 ☐ Cremation 3 ☐ Removal from State BATTMORE, MD 4 Donation 5 Other (Specify) AUGHN GREENE FUNERAL SCKS Signature **Euneral Service** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to or as a consequence of) **Examiner** equantially flet conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events signed by the attending physician and Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Pregnant at time of death page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director; After this certificate I filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of D ath 28b. Time of 28c. Injury at work?
1 \(\sum \) Yes 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On tigle basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practifioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 29d. Date signed (Month, Day, Year)

State Registrar MORE

o completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ess of perso

OCT 1 6 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day Year Month 2012 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 85 1 X M 2 □ F June 15, 1927 10b. County 10c. City, Town or Location Catonsville Baltimore 10f. Zip Code 10g. Citizen of What Country? 21228 United States

For State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Gart Westerhout 150 Medical 4a. Facility Name (if not institution, give street and number, Examiner Charlestown Retirement Center Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 568-58-9177 Director Netherlands 28a-f show ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland 10e. Street and Number Funeral 719 Maiden Choice Lane, #502BR 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than ' College (1-4 or 5+) 5+ Elementary/Secondary (0-12) traumatic event, the University/Observatory Astronomer marked other Be Permit. Page 1 and 2 should be filec.
Department of Health and Mental Hy, Important: If item 27 is marked—any injury or other to—once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Magda H.M. Foppe Gerrit Westerhout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Ln., #502BR, Catonsville, MD 21228 Judith M. Westerhout/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State Metro Crematory Inc. 10/15/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc Taylor 21. Signature of Funeral Service Licensee Alyson K 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Ent. I the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Congestive disease or condition resulting in death) Medical Due to or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death the 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed death? Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation
6
Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3 D44377 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lane, Cotonsville, mp 21228 Deneen Maiden Choice Bou 31. Date filed (Month, Day, Year) State Registrar

200

Wester

1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lawrence C. Whitmer 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) Hours 212-36-3543 **Director** 1**X** M 2 □ F 74 12-19-1937 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location the Maryland Director notified MD Baltimore Essex 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 292 Montrose Ave. 21221 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status an "natural", or iter Medical Examiner Armed Forces? 1 Yes 2 □ No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give 3 XWidowed 4 Divorced Year or Dates other, Lawrence 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than alth and Mental Hygiene. 27 is marked other than traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) Electronics 12 Electronics Tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Lory Aaron Whitmer Mamie V. Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Matthew Whitmer-son 810 Windsor Dr., Westminster, MD Department of Healt Important: If item 2 any injury or other once. injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Winfield, MD 4 Donation 5 Other (Specify) South Carroll Crem 10/15/12 Signatur Affluneral Service Licensee 22. Name and Address of Facility Fletcher Funeral & Cremation 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician/ DOWE Medical resulting in death) Examiner rcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence on the a ending physician and ched for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) in the past 12 months? 1 Yes 2 No g Unknown 9 Unknown P.O. ģ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an has page 2 autopsy perform Director: After this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 1 🗹 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Mapher of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FRANKLIN Square DR, Suite 300, Baltimore, MD 21237

10:00

Birthplace (State or Foreign Country)

Approximate Interval Between

Onset and Death

10d. Inside City Limits

1 Yes 2 No

4c. County of Death

USA

Baltimore

MD

14. Race - American Indian,

Black, White, etc.

Specify.white

23d. Date of delivery

Day

24b. Were autopsy findings available

prior to completion of cause of death?

1 Yes 2 No

State Registrar

only one 29b. Signature

Mempe

ppleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

469248

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ oc^möber 20⁴12 199 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GREATER BALTIMORE MEDICAL TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Manth, Day, Year) 9. Birthplace (State or Foreign Months Min. Days Hours 19-18-0300 Director 1 M 2 D F permit. Pege 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mentei Hyglene. Importent: If Item 27 is merked other then "neture!", or Items 23e or 28e-f ehov any Injury or other treumetic event, the Modical Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 10e 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Thomas Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify 3 ₩Widowed 4 ☐ Divorced If Yes, Give Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) (Qecondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 99 W19912 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ihomas Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause injury Due to (or as a consequence of): Examir To the Hospitel or Attending Phyelcien: The lew requires that the deeth certificate be executed within 24 hours effer death.

With the Funeral Director: After this certificate has been signed by the ettending physicien end completely filled in by the Interial director, page 2 should be detached for use as the burlei-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Day, Year

3. Time of Death

9:10 AM

1 Yes 2 No

State Registrar 31. Date filed (Montl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sara Lee Woolford 00:20 AM 2012 Medical OCT 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Levindale Baltimore N/A5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TX Min Hours 216-34-6652 1¹2²7¹1 ¹5³/ Mary land 72 1939 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Co. 1 🗌 Yes 2 🔀 No Pikesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3911 7 Mile Lane Apt B1 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montebello St. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse years Hospital other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bert Robinson Elizabeth Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21208 Charisse Coles(Niece) Warren Park Dr. #C4, Pikesville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 DeBurial 2 Cremation 3 Removal from State Mt. Zion Cem. 10/17/12 Baltimore, MD 4 Donation 5 Other (Specify) . Signatur of Funeral Service Licensee Fosephadiss Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be execute the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Respiratory 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an certificate has b irector, page 2 sl autopsy performed? Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 잍 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) D0063327 Durm H. WordEHEAUT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. BELVEDERE AVE, mo 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Lucille M. Wilson 2012 September :00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 621 Clark Avenue Deale Anne Arundel 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Director 1 🗆 M 2 💢 F 412-30-8784 Usual Residence of Decede 89 8, 1923 Kentucky 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No Deale MD Anne Arundel 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 621 Clark Avemie 20751 Il Hygiene. I other than "natural", or items vent, the Medical Examiner mu permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2X No ☐ Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>bookkeeper</u> automotive of Health and Mental Hygi item 27 is marked other other traumatic event, it Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 John F. Sneed Stella Jane Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Shannon Veranas/daughter 621 Clark Avenue Deale, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🗀 Cremation 3 🗔 Removal from State cemetery, crematory or other place ö Department of Important: If any injury or once. 4 Donation 5 Qther (Specify) 21. Signature Funeral S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ANCER. Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 9 Unknown Month Day Year ed by the all detached for signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 L No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinating and/or investigation is my an

State Registrar (Check

only one) 29b. Signature and title of certifie

3

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Si

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 14 October W. Wolfe 2012 05:55 PM Farl Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health & Rehab <u>Glen Burnie</u> Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Days Director 236-28-2011 1 X M 2 □ F 89 Sept. 17 1923 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadaena 1 ☐ Yes 2 🛣No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 546 Sunset Knoll Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical soce. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Watchmaking Watchmaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wolfe Glaspy Josephine Southerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wolfe 4705 Henshaw Lane, Pasadena, MD 21122 (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. Date 17 1 X Burial 2 Cremation 3 Removal from State Meadowridge Cemetery 2012 4 Donation 5 Other (Specify) Elkridge, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final KIDNEY HRONIC DISEASE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ENCEPHALOPATHY TABOLT C Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): YPERTENSION or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical DEMENTIA Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🏲 No
9 ☐ Unknown 5 Other (specify) Month Day Pregnant at time of death 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by t completely filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 M Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN D58580 10/15 /20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAT KANII. 3233 SUPERTOR LN. B21 BOWIE, MD 20-715 KANU . 3233 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 6 2012 Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Prin		ndelible Ink. Ensure artment of Health and		•).
	•	1 - State Registrar		tificate of Death	,	Reg. No. 201	2 2210
Dhysisis	/	Decedent's Name (First, Middle, Last)	1		2. Date of Dea	ath _	3. Time of Death
Physicia Medic	al	Viera de Chize	Willia	mson	Month Oct.	10 2012	- 12:45 PM
Examin	er	4a. Facility Name (if not Institution, give street and number) FMECINS OF でいらい		4b. City, Town, or Location of Deal	th	4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		h 9. B	more irthplace (State or Foreign ountry)
Director		Usual Residence of Decedent	86 Yrs.	The line of the li	Sept. 2	3 1926 1	V.V.
/land f show d at	tor	10a. State 10b. County	10c. City, Town or Loc	cation		/ / / /	10d. Inside City Limits
e Man r 28a- notifie	Director	10e. Street and Number	10ws				1 🗆 Yes 2 🗗 No
with th	Funeral	16451 N. Charles	4	10f. Zip Code		10g. Citizen of What C	ountry?
death items ner mu		11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13. V	Vas Decedent of Hispanic Origin? (Sf Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Am	
after al", or Exami	d by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced Armed Forces? 1 ☐ Yes 2 ☐ No. If Yes, Give Year or Dates.	1	☐ Yes 2 ♣No Specify:	,	Black, Whi	te, etc.
2 hours "natur dical I	plete	15. Decedent's Education (Specify only highest grade completed)		lent's Usual Occupation kind of work done during most of wo	rking	16b. Kind of Business	s/Industry
ithin 7; ene. r than the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life DC	NOT use retired)	ining	Sac: 18	Les tion
permit. Page 1 and 2 should be filed within 72 hours after death with the Mavjand Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. The man are stated other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	17. Father's Name (First, Middle, Last)	I Racy	18. Mother's Na	me (First, Middle, I	Maioen Surname)	aucanory
Ild be I Menta narked natic e	ᅀ	Alet de Ghize		Eleano	r Ma	y Jench	<u> </u>
2 shorth and 27 is not 27 is not raun		19a. Informant's Name/Relationship (Type, Print) Eleavor Elbers days days her	19b. Mailin	g Address (Street and Number or Ri	ural Route Number,	dity or Town, State, Z	ip Code)
of Hea of Hea fitem		20a. Method of Disposition	20b. Place of Dispos		Date	20c. Location - City of	r Town, State
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hysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	entica				Interval Between Onset and Death
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has be	Completed				24a. Was a	sv prior to	utopsy findings available completion of cause of
tificate tor, pag	Be Co	25. Was case referred to medical		26. Place of Death (Che			s 2 No
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h. After t	w	27. Manner of Death 1 → Natural 5 □ Pending 28a. Date of injury (Month, Day, Y	/ear) 28b. Time of injury	28c. Injury at work?		ow injury occurred	
er deat ector: by the	Certificat	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury	- At home, farm, stree	M 1 Yes 2 No et, factory, office		reet and Number or Ru	ural Route Number,
ral Dir	ا <u>ت</u>	building, etc. (\$			City or Towr		
The proposal of meetings riversely in the law requires that the death centure to the proposal of the proposal	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examiners) only one. 2 Certifying Nurse Practification T. the basis of examiners only one.	mination and/or investig	gation in my opinion death occurred	at the time date an	id place and due to the	cause(s) and manner stated
within To the compl		29b. Signature and title of certifier	cat or i ji ki okikaga	29c. License number	2	29d. Date signed (Mont	
		Marchin		D58301	3 6	OCTOBER	P 5015
6		30. Name and address of person who completed cause of deat		6701 N.Ch	CARCAN	CT TOSA	0W WO
State		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	010/10/000	-1200	31 1000	
Registra	r	QCT 1 6 2012 Senew &	1. garks				

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 6:17 a M Theresa Frances Wesolek October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) **Director** 219-18-3120 1 □ M 2 🖾 F Maryland 86 Nov. 5, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🔀 No Harford Maryland Pylesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral USA 1149 Old Pylesville Road 21132 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Force Black, White, etc. ☐ Yes 2 🛛 No þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other than Injury or other traumatic event, the once. 12 Cafeteria Worker Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Minnie Gertrude Lutner Clark Joseph Ambrose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Smith / Daughter P.O. Box 96, Pylesville, MD 21132 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗷 Burial 2 □ Cremation 3 □ Removal from State 10-16-12 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Pol. Cem. McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequent of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examir Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal Geal
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown

Physician/ Medical **Examiner**

iding physician

Box

P.O.

Records,

Division of Vital

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21215-0036

Baltimore, Maryland

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should be filed within 72 I n and Mental Hygiene. 7 is marked other than "r

burial-trar page 2 within 24 hours after death.

To the Funeral Director: After this completely filled in the compl

Completed 25. Was case referred to medical Be ပု 27. Manner o Certificate:

Medical

1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 24a Was an

	1 🗌 Yes	2 No	1 Yes
on.	ly one)		
ne	5 🗌 Resid	dence 6 🗌	Other (Specify,

autopsy performed?

2 No

Yes 2 No	ospital;	ER/Outpatient 3	□ DOA	Other: 4 Nursing	ing Home 5 Residence 6 Othe
Natural 5 Pending Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.	Injury at work? 1 Yes 2 No	28d. Describe how injury occurre

Suid 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier		Certifying Physician: To the best of my knowledge, death occur						
(Check only one)	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner st 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature	nd title	of certifier	29c. License number	29d Date signed (Month Day Year)				

26. Place of Death (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospin Shakmar, MD 602 Atward Rd Swite 206 Beldin, Md 21014

State Registrar 31. Date filed (Month, Day, Year OCT 1 5 2012 32. Registrar's algnatur

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8,20b, per fh, g932 10-16-12 sm State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Joseph Aaron Woolman 1940 М 12 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Km 6486 suburban Bethesda, MD Montgomen Hospital If Under 1 Year If Under 24 Hrs, g. Birthplace State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** Days Hours Min Director 087-14-8214 1 ☑ M 2 🗆 F UKRAINE 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🕅 No MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10401 GROSVENOR PLACE, #1301 20852 USA death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. \$ 1 Never Mamied 2 Married Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify "natural", Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the ATTORNEY LAW permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental H 2 BORKER IRVING WOOLMAN RACHEL 19a. Informant's Name/Relationship (Type, Print)DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARCIA WOOLMAN GOLDSMITH 860 ROSCOMMON ROAD, BRYN MAWR, PA 19010 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BETH EL MEMORIAL PARK 10/11/2012 4 Donation 5 Other (Specify) RANDALLSTOWN, MD 21. Signature of Funeral School Livens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition POKE Medical resulting in death) Due to as a consequence of): Examiner neumon. Sequentially list conditions, for y fracting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Districtor as a consequence of Exami Hospital or Attending Physician: The law requires that the death certificate be executed HF attending physician and I for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Medical Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) ed by the a q | Unknown 24 hours after death.
2 Funeral Director: After this certificate has been signed the femal principal interpretation by the funeral director, page 2 should be defined willed in by the funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 2 1 No ٩ 1 🔲 Yes 1 ☐Anpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in the cause of examination and or investigation and or Medical 29a. Certifier mpletely (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 10-9-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23c per doc 9937 3-6-13 yr **item 23c per doc g937 3-6-13 yt** State of Maryland Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 Darlene Marie Wood 12:03 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 336 Oldham Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** 1 M 2 F Min. (MOCT) / Day Year) 4 Months Country Maryland 219-62-1428 58 **Director** Usual Residence of Dec or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a (Funeral 336 Oldham Street 21224 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deced Armed Forces? 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 1 Never Married 2 Married by 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify 3 Widowed 4 Divorced Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event "to "..." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Did Not Work N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Unkn. Lillian Sands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Cooper / Daughter 336 Oldham Street, Baltimore, MD 21224 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory 10/13/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, Po Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Hemochromatosis Physician: The law requires that the death certificate be executed -tran resulting in death) Last Due to (or as a consequence of) burialphysician sthe burial Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for Pregnant at time of death the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an . Were autopsy findings available prior to completion of cause of has autopsv death? After this certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita 2 / No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending injury 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ucrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29d. Date signed (Month, Day, Year) 2

Registrar

DHMH 17 Rev 06-2011

State

OCT 16

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registra I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Youn Physician/ Month 11:40 am reorge Septembe Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's PNINCP Hospital Center heverly 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 Year **Funeral** Hours 579-90-0052 **Director** 1 🔀 M 2 🗆 F Usual Residence of Decedent 53 Dec.11,1958 r 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington, D. 10e. Street and Number 10g, Citizen of What Country? ŏ 10f. Zin Code ms 23a or Funeral 216 58th Street N. Ε. 20019 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces Black, White, etc. ò ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Clerk Private Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H
27 is marked ot
traumatic ever George Edward Young permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Betty Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Young/Sister 216 58th Street N.E., Washington DC 20019 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/23/12 Beltsville, MD Chesapeake Crem Signature of Funeral Service Licensee 22. Name and Address of Facility AUstin Royster Funeral Home 14th Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 D Unknown peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? this certificate 1 Yes 2 No 2 1 N Yes within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 In ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie

State Registrar Day,

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12-07471		Please Type or	Print in B	ack Inde	lible Ink.	Ensui	re All Copi	es Are Leç	gible.		
Brian Edwin Angle	9	State of	of Maryland				nd Mental F	lygiene		2013	3318
		1- For State Registrar		Certifi	cate of De	eath		Re	g. No.	2016	2 3310
Physician	_	Decedent's Name (First, Middle,Last)			-			Date of Deat Month		Year	3. Time of Death
Medical Examin	er	Brian Edwin ANGL	E					October 2	Day , 2012	real	1245 hrs
		4a. Facility Name (if not institution, give	street and number)		4b. C	ity, Town, o	r Location of Deat	h	4c. (County of Death	
		829 Mulberry Avenue			H	agerstow	n		W	ashington	
Funeral	7	Social Security Number 6. Sex	7. Ag	e (In yrs. last b	oirthday) If	Under 1 Yea	ar If Under 24Hr	s. 8, Date of 8 in	th(MM/D	D/YYYY) 9. 8 irti	
Director		212-94-0243	M 2 F	49	Yrs.	onths Day	ys Hours Mi	Sept.	12 1	963 Foreign	ntnMaryland
	ŀ	Usual Residence of Decedent		77				осрег		, , ,	
any any	ŀ	10a. State 10b. County		10c. City, Tov	n or Location						10d. Inside City Limits
. ₹	L۱	Maryland Washing	ton	Нада	erstown						1 X Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number		1148		. Zip Code		10	0g. Citize	n of What Coun	try?
or 28	<u>e</u>	200 11			1	017/			TTO	A	
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s after	2	15. Decedent's Education (Specify onl	or Dates:	nnlotod) 16:			ation (Give kind of	work done		nd of Business/Ir	
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Ital Records, P.O. Boy ician: The law requires that the death s certificate has been signed by the attractor, page 2 should be detached for		Part II. Other significant conditions	contributing to deat	h but not result	ing in the under	lying cause	given in Part I.	23e. Did to	bacco us	se contribute to t	he cause of death?
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical		On the basis of exa and manner stated.	mination and/o	investigation,			at the time, date			
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		toI !! -	Toller			O.C	.M.E.		Octo	ber 3, 2012	
	ŀ	30. Name and address of person who or	ompleted cause of	eath (Item 23a	1)						
ON-31		Patricia Aronica-Pollak MD	. Assistant N	/ledical Exa	miner 900) W. Balti	more Street,	Baltimore, MI	D 2122	23	
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10:45 A October Susan Jemima Ancarrow /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Smithsburg Washington County 11939 Comanche Dr. 9. Birthplace (State or Foreign Country) D.C. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 21 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Months Days Hours 212-38-7673 70 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State r than "natural", or items 23a or 28a-f show the Modical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Washington County Smithsburg 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code U.S.A. 21783 11939 Comanche Dr. by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Specify: White 1 □Yes 2X No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hospital Medical Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HelenForrest Maxel Robert Edward Daugherty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau Clarence L. Ancarrow-husband 11939 Comanche Dr. Smithsburg, MD 21783 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Lawn Mem. Park 10-5-2012 Hagerstown, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death set and Death YEAR HEIMER'S Immediate Cause (Final DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, and light immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conse tience of Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be Certification: To

I or Attending Physician: The law requires that the death certificate be executed after death. use as the burial-tran the attending physiclan and Division of Vital Records, P.O. Box 68760, signed by the has been page 2 s this certificate To the Funeral Director: After this certific completely filled in by the funeral director, Hospital within 24 hours a

To the Funeral L

filed within 72 hours after death with the Maryland Hygiene.

and Mental Hygi is marked other

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

28a-f show

							1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
							24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referre	ed to medical				26.	Place of Deat	th (Check only one)
examiner? 1 ☐ Yes 2 ☑	vo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA	Other: 4	☐ Nursing Ho	ome 5 Residence 6 □ Other (Specify)
27. Manner of Death 1 Matural 2 ☐ Accident	5 ☐ Pending investigation		28b. Time of Injury	28c.	Injury at Work? 1 ☐ Yes	2 □No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		nome, farm, street, ify)	factory, of	ffice		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier	Certifying Ph	nysician: To the best of my kn	owledge, death oc	curred at	the time, d	ate and place	e, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) ber 3, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) //// MEDICAL CAMPUS

HAGERSTOWN

JW-6 Registrar

32. Registrar's Signature

and manner stated

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Aparicio September Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Johns PKINS HOSPIta altimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/05/2012 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Min. Hours Virginia Director 814-10-2537 1 M 2 STF 7 17 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumetic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 No MD Prince Georges Bowie 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 20720 USA 9006 Wipkey Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 2 1 X Never Married 2 Married Maryland 21215-0036 1 ☑ Yes 2 ☐ No SpecifySalvadorean If Yes, Give Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) none none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Glenda Maricela Aparicio Moran Manuel de Jesus Mejia Garcia 19a. Informant's Name/Relationship (Type, Print) father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manuel deJesus Mejia G. 9006 Wipkey Court Bowie, MD 20720 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Family Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 9/30/12 El Salvador 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Manda C. Bacon cc0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final esia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the huridate and Exam sician and Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death Month 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 No death? 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certificate: To 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 Matural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number \mathcal{Q} RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St. Baltimore MD, 21287 Melisca Fussell, MD

State

Registrar

31. Date filed (Month, Day, Year)

25

back

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ,2012 Sept.21 12:05p ^M <u>Gustav</u> Ngwa Asana Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Director 670-18-6753 1 🔀 M 2 🗆 F 61 1/30/1951 Cameroon other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Silver Spring 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 2801 Radius Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Healthcare 5+Be it. Page 1 end 2 should be filed rtment of Health and Mental Hy rtant: If item 27 is marked oth njury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ David Asana Monica Bi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget Asana/Wife 2801 Radius Road Silver Spring, Md 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o once, cemetery, crematory or other place) 1 🔀 Burial 2 🗀 Cremation 3 🔀 Remoyal from State 10/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery Bafut, Cameroon Signature of unoral Service 22 Name and Address of Facility PHILIP D.RINALDI FUNERAL SERVICE, P.A Blvd.Silver Spring, Md20910 241 Columbia 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Onset and Death months Immediate Cause (Final Physician/ disease or condition resulting in death) a. Systemic amyloidosis Medical Due to (or as a consequence of) Examiner Autonomic dysfunction months Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that in the last or the cause of the caus Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and gompletely filled in by the funeral director, page 2 should be detached for use as the hurtel thems. for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pleural effusion, hypertrophic cardiomyopathy, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an <u>diarrhea,anasarca</u> autopsy 1 Yes 2 No ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 反 No Other: Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature/and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0057630 Sept.22,2012 Uln 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Anuradha</u> Arun 10301 Georgia Avenue #209 Silver Spring, Md 20902 D 31. Date filed (Month, Day, Year) SEP 2 6 2012 State Registrar

Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:45P M Russell Ayres replember 20,2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Doctors Hospital Lanham 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) Hours **Director** 214-42-8699 1 **X** M 2 □ F 10/03/1944 67 MD ral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince Georges Landover 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2208 Brightseat Rd., apt. 201 20785 AZU 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 X Married Black White etc 1 X Yes If Yes, Give 2 No Maryland 21/215-0036 Black 1 Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) US Post Office 12 Postal Clerk Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-mportant: If item 27 is pro-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Ayres, Sr. Madelyn Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 1742 Catherine Fran Dr., Accokeek, MD 20607 Angela Venson / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) MD Veterans Cemetery 10/01/2012 Cheltenham, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Lice 6500 Allentown Rd., Camp Springs, MD 20748 Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ CANCER disease or condition resulting in death) CUN , Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): requires that the death certificate be executed physician and is the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEFICENCY SYNDRO page 2 should 1 Yes 2 No 3 Probably 4 Unknown me 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The law has autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital 1 🗌 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) . 24 hou. Medical 1 Secrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United Inc. (See Examine) of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certi D0050951 5JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suito 2400, Riverdale, MD. 20737 Kenilworth Reva Gill MD. State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #16a&b Per FH G933 11/06/2012 III amend #16a&b Per FH G933 Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month 09 Year 0934 AM Louise Helen Allen 2012 Medical 4a Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death comi If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Min (Month, Day, Year) 215-26-5115 Usual Residence of Decedent Director 1 □ M 2**X** F 84 -8-1928 MD ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Worcester Pocomoke 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 602 Young Street 21851 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. SpeciBlack Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) US Inspector Elementary/Secondary (0-12) College (1-4 or 5+) Perdue, Inc. should be filed with and Mental Hygien is marked other ti 12 Housekéeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Willie Wise, Sr. Mamie Whelton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trau Young Street, Pocomoke City, MD 21851 William E. Allen/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Sinai Bapt Cem9-29-2012 Pocomoke City, MD Signature Funeral Service Licensee 22 Name and Address of Facility Bennie Smith 917 W. Isabella St. Ul Funeral Salisbury, Home 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician WOOWRTRIAL disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence oi). ii ariy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami that the death certificate be executed physician and sthe burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 use as attending plant for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Unknown ed by the a detached f g Unknown signed by t d be detact Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed eral Director: After this certificate I filled in by the funeral director, pag Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Mother (Specify) HOSPICA ပ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 12058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hugy SALISAMED 31. Date filed (Month, Day, Year) egistrar's Signatur State 28 SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 928M Marvin Walter BISHOP Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown Meritus Medical Center . Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Months Hours 212-14-7386 Director 1 🛛 M 2 🗆 F 91 Yrs June 10, 1921 Maryland Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21740 USA 18013 Oak Ridge Drive hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. WW II "natural", Specify. white 3 K Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working 72 Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) communication technician electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F P Victoria Creek Walter Adison Bishop other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a it item 27 is Donna Hovermill - daughter 1113 Beechwood Drive, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State ō Department of Important: If any injury or Rest Haven Cemetery 10/5/12 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Furnial Service Licensee 2. Name and Address of Facility MINNICH FUNERAL HOME muce 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ONGPTIVE disease or condition resulting in death) Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed ordem a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed? certificate 1 Yes 2 No Yes 2 10 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🕞 No ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ☐ ER/Outpatient 3 ☐ DOA this n 24 hours after usame re Funeral Director. After the coletely filled in by the funeral 27. Manner of Death 28a. Date of injury 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29d. Date signed (Month, Day, Year) 0061117 ted cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp Daniel Francisco Meri 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James K. Briscoe State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death James Kennedy Biscoe **Medical Examiner** 0559 hrs September 29, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9106 Pine View Lane Clinton Prince George's 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months 217-88-9314 Days Hours Min. 1X M 49 2 F 10/10/1962 Country) Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits timore, MD 21215-0036

1. Pages I and 2 should be filed within 72 hours after death with the Maryland fracent of Health and Mental Hygiene.

Trant: If item 27 is marked other than "natural", or items 23a or 28a-f ahov y or other fraumatic event, the Medical Examiner must be notified at once. MD St. Mary's Lexington Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46704 Midway Drive 20653 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married White, etc. 1 Yes 2 X No Black 3 Widowed Divorced Give Year 1 Yes 2 No specify: Specify: 5 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Labor Private 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ed Joseph Biscoe, Sr. Mary Barbar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamie Shammara Biscoe/dtr. 46109 Pleasant Dr. Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Baltimore, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State harle:Memorial Carden 10/05/2012 Leonardtown, MD 4 Donation 5 Other Specify anature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington RD Waldorf, MD 20601 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line. /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical signed by the attending physician is be detached for use as the burial UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy 2 Month Year Day Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? é Endocarditis; Chronic renal failure; Chronic ethanolism 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 2 No To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifit 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c, Injury at Work? Certification 1 V Natural I Director: ed in by the f 5 Pending 1 Yes 2 No 2 ___ Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. September 30, 2012 30. Name and address of person who completed cause of death (Item 23a)

31. Date filed (Month, Day Year) 2012 Registra

Ana Rubio M.D., Ph. D.

Assistant Medical Examiner 32 Registrar's Signatur

900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kimberly Loretta Williams Broadway sept. 22 pay 2012 12:15 pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Shady Grove Hospital Rockville Montgomery 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days 577-96-1666 Director 1 □ M 2 1 F 53 08/20/1959 New York item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, <u>the Medical Examiner must be notified at</u> within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits Md. Montgomery Rockville Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 534 Rutgers Street 20850 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black White etc. ۾ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'a may injury or other traumatic event, the Meone. Elementary/Secondary (0-12) 10th College (1-4 or 5+) Housekeeping Dept. of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Williams Ella Mae Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tamiko Williams 534 Rutgers Street Rockville, Md. 20850 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 10-1-2012 Beltsville, Maryland ^{22.} Name and Address of Facility Latney's Funeral Home 3831 Georgia Ave., NW 21. Signature of Funeral Service Licensee CC0530 Washington, DC20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Priysician/ Onset and Death ardicoulmonary Medical resulting in death) Due to (or as a consequence of): Examiner anced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit ericardial effusion To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical malnutrition 68760 Calorie IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. σ. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be (25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

State

Registrar

31. Date filed (Month, Day, M

SEP

enia

60

Center Drive Rockville

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ September 20, 2012 Morgan Maxfield Busch 6:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Hours Days **Director** 529-34-0330 1 **X** M 2 □ F 81 April 9, 1931 IItah Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Directo 28a-f 1 Yes 2 X No MD Montgomery Silver Spring 10e, Street and Number 10g. Citizen of What Country? Funeral items 23a 2500 Jennings Court 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian 5 Black White etc. φ 1 Never Married 2 Married 1 St Yes 2 □ No If Yes, Give Year or Dates.1948-91 2 No Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: "natural", Completed 3 ☑ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Project Supervisor Dept. of Navy other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental Fish and Mental Fish ဥ John Thomas Busch Helen Elizabeth Blackburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Helen Kathleen McBride/Daughter 3001 Plyers Mill Road, Kensington, MD 20895 Baltimore, Date 1, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Oct. 4 ☐ Donation 5 ☐ Other (Specify) Ferron Cemetery 2012 21. Signature of Funeral Service Licensee _22. Name and Address of Facility Francis J. Collins Funeral Home Inc. EMAS 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caus whe death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of Examine Cardiogenic Shock Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Obsease or injury Due to (or as a consequence of) burjal-transit death certificate be executed Cardiomyopathy that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown ed by the a detached t P.O. or Attending Physician: The law requires that the s been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has it autopsy After this certificate funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 🗆 Yes 2 🔀 No မှ Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After rempletely filled in by the funeral present the funeral p 28d. Describe how injury occurred 1 Matural
2 Maccident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 06-201

State

1500 Forest Glen Road, Silver Spring,

MD 20910

s of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signat

MD

Gebremedhin Yohannes,

31. Date filed (Month, Day, Year) SEP 25

Physicia Medic Examir

Funeral

Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/

Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and empletely filled in by the funeral director, page 2 should be detached for use as the burilitzagit Division of Vital Records, P.O. Box 68760

	1 - State Of IN State Of IN Registrar	naryland / Depa Cer	artment of He tificate of De		,	giene Reg. No. 20	112 3	3196
in/	1. Decedent's Name (First, Middle, Last) CIURER LEE H. 13	ROWN			2. Date of De Month	Day	Voor	e of Death
er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo			4c. County	of Death	00 H
	MESSTAR HARBOR HOSP / 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)		If Under 24 Hrs.	8. Date of Birl		9. Birthplace (Sta	te or Foreian
	219-80-2393 1□M2፟ÅF	53 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) .7,1959	Country) MARYLAN	
ŏ	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		nee. I	7,1000	T	e City Limits
rect	MD. ANNE ARUNDEL	G	LEN BURNII	Ε			1X	Yes 2 No
al Di	10e. Street and Number		10f. Zip Code			10g. Citizen of V	Vhat Country?	
ner	7841 LEYMAR RD.	Samuel II o		060	77. 37. 31		S.A	
Completed by Funeral Director	11. Marital Status 12. Was Decedent Armed Forces 1 □ Never Married 2 □ Married 1 □ Yes 2 🛣	?] No	Vas Decedent of Hisp f Yes, specify Cuban,	Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - American Indian k, White, etc.	ı
ted t	3 ☐ Widowed 4 【XDivorced If Yes, Give Year or Dates.	1	☐ Yes 2 X No	Specify:		Specify:	WHITE	
uple	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupation		king	16b. Kind of Bu	siness/Industry	
Con	Elementary/Secondary (0-12) College (1-4 or 12	0+)	O NOT use retired) COMMERCIAI	CLEAN	NG	SEL1	F EMPLOYE	σ
) Be	17. Father's Name (First, Middle, Last)					Maiden Surname		
J D	DONALD WEAVE	R			SHIRLEY	TROX	KELL	
	19a. Informant's Name/Relationship (Type, Print)	I	g Address (Street and					
	DAVID HARAWAY / SON 20a. Method of Disposition	20b. Place of Dispos	RIVERVIEV sition (Name of	V TERR.	Date SAINT		S, MD, 21 City or Town, State	
	1 Ma Burial 2 ☐ Cremation 3 ☐ Removal from Stat	~	COLN CEM.	9-26	5-2012		VOOD, MD.	
	21. Signature of Funeral Service Licensee	7) 22 C	Name and Address of HAMBERS FU	of Facility JNERAL H	IOME & C	REMATOR	UM.P.A.	1
Т	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir	ed the death, Do not ente	801 CLEVEI or the mode of dying, s				Approxir	
	Immediate Cause (Final disease or condition		VARIAN	CANCA	=D		Interval I Onset ar	Between nd Death
	resulting in death) Due to (or as	a consequence of):		0/11000	. 1 C			
er	Sequentially list conditions, bb	a consequence of):						
Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence on.						
EX	that initiated events resulting in death) Last C. Due to (or as	a consequence of):		-				
dica	d		 -			_		
J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome	e of pregnancy						
icial	in the past 12 months? 1 Uive Birth 1 Pregnant	2 Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Dat Mor	e of delivery nth Day	Year
Phys	9 ☐ Unknown 9 ☐ Unknown							
by	Part II. Other significant conditions contributing to death	but not resulting in the ur	nderlying cause given	in Part I.			bute to the cause of	
etec					V		3 Probably 4	- 1
dwo					24a. Was a autop perfor	med? d	lere autopsy finding rior to completion c eath?	
e C	25. Was case referred to medical		26. Place	of Death (Chec	1 ☐ Yes	2 No 1	Yes 2 No	
일		ient 2 ER/Outpatient	Other			ence 6 Othe	r (Specify)	
ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Death of Injury)		28c. Injury at work?		28d. Describe h	ow injury occurre	d	
iği Li	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of In	ury - At home, farm, stre		s 2 🗆 No	28f Location (S	traat and Numba	r or Rural Route Nu	mhor
ပိ	4 ☐ Homicide determined 286. Place of in building, ef	c. (Specify)	ot, rastary, smos		City or Town		or nural noute Nu	mber,
Medical Certificate: To Be Completed by Physician/Medical	29a. Certifier (Check Check only one 3 Certifying Physician: To the basis of Certifying Nurse Practitioner: To the	examination and/or investi-	gation, in my opinion, o	death occurred a	the time, date ar	nd place, and due	to the cause(s) and	manner stated.
	29b. Signature and title of pertiller	- sugesting a philosophic	29c. License nu	ımber			(Month, Day, Year)	
	· Codt for M.		\$298	107		092	012	
	30. Name and address of person who completed cause of a CARUS b - Z (FEL_M.), r	death (Item 23a) (Type, Pr	int)	RA	TIMIND	E al	7.12.2	_
e	31. Date filed (Month, Day, Year) 32 Registr	300 S HA. ar's Signature	100 VETE 51	e 137	Ci more	c, mo	. 0122	٦
r	SEP 2 5 2012 Cerus	J. Alan	Chair -					

Stat

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012 3319				
Ċ	Physicia Medi		1. Decedent's Name (First, Middle, Last) JOANNA B. BERGSTEN 2. Date of Death September 23, 2012 8:00 AM				
-	Examir	ner	4a. Facility Name (if not institution, give street and number) Andrus House 4b. City, Town, or Location of Death Rockville 4c. County of Death Montgomery				
8	Funeral Director		5. Social Security Number 100-30-0132 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 75 Yrs. 7. Age (In yrs. last birthday) 1				
	faryland Ba-f show iffied at	Director	10a. State				
	with the M 23a or 28 ust be not	Funeral Dir	10e. Street and Number 10910 Old Georgetown Road 10f. Zip Code 20852 10g. Citizen of What Country? United States				
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: White				
Baltimore, Maryland 21215-0036	l within 72 ho /giene. ner than "na t, the Medic	e Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Homemaker 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own Home				
yland	ild be filed Mental Hy tarked oth atic even:	To Be	17. Father's Name (First, Middle, Last) David Barnard 18. Mother's Name (First, Middle, Maiden Surname) Eleanor Collins				
, Mar	nd 2 shou lealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) Lynne M. Jarman (Daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18816 Liberty Mill Road, Germantown, MD 20874				
imore	Page 1 a ment of H tant: If ite lury or oth		20a. Method of Disposition 1 Disposition 1 Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Disposition (Name of cemetery, crematory or other place) Metropolitan Crem. 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crem. 20c. Location - City or Town, State Alexandria, VA				
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877				
	Physician/		23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Coronary Artery Disease				
	Medical Examiner	_	resulting in death) Due to (or as a consequence of): Hypertension b.				
104	cuted and training the state of	Examiner	if any, leading to immediate cause. Littler Underlying Cause (Disease or injury that initiated events c.				
90	ate be executed physician and the burial tersit		resulting in death) Last Due to (or as a consequence of): d				
. Box 687	requires that the death certificat been signed by the attending ph should be detached for use as th	Physician/Medical	FEMALE: 23b. Was decedent pregnant in the past 12 months? 1				
s, P.O.	ires that tl signed by Id be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown				
Records,	The law requires that the ate has been signed by the page 2 should be detach	Completed	24a. Was an autopsy performed? death?				
		Be	25. Was case referred to medical examiner? 1				
25. Was case referred to medical examiner? 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home 5 Residence 6 X Other 27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28. Place of Injury 2 28b. Time of injury at work? 1 Yes 2 No 28d. Describe how injury occurred work? 28d. Describe how injury occurred work? 28d. Describe how injury occurred building, etc. (Specify)							
28d. Describe how injury occurred work? Table Tab							
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	Noth with 25 com		29c. License number 29d. Date signed (Month, Day, Year) D41162 September 24, 2012				
			Dr. Vinu Ganti M.D. 19529 Doctors Drive, Germantown, MD 20874				
	Stat Registra	_	SEP 2 5 2012 Registrar's Signature SEP 2 5 2012 SEP 2 5 2012				

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Men 1 - State Registrar Certificate of Death	2012 33108
1. Decedent's Name (First, Middle, Last) Physician/ BRENDA SANCROFT BAKER 2. Decedent's Name (First, Middle, Last)	Reg. No. 2012 33130 Date of Death Month of Death Month of Death 10:00 AM
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
12221 Bradbury Drive Gaithersburg 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 1 If Under 24 Hrs. 1 8, 1	Montgomery
Director 217-44-3065 1 \square M 2 Σ F 67 Yrs. Months Days Hours Min. Oc	Date of Birth Month, Day, Year) 2t. 3,1944 9. Birthplace (State or Foreign Country) New Jersey
10a. State 10b. County 10c. City, Town or Location 10a Maryland Montgomery Gaithersburg	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
Total State 100. County 101. City, Town or Location Gaithersburg 101. City, Town or Location Gaithersburg 102. City, Town or Location Gaithersburg 102. City, Town or Location Gaithersburg 103. City, Town or Location Gaithersburg 104. City, Town or Location Gaithersburg 105. City Town or Location Gaithers	10g. Citizen of What Country? United States
Armed Forces, Specify Cubari, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: White
980-51 Image: Specify Cuban, Mexican, Puerto Ricar Image: Specify Cuban, Puerto Ricar Ima	16b. Kind of Business/Industry Montgomery County Public Schools
To be the property of the prop	st, Middle, Maiden Surname)
19a. Informant's Name/Relationship (Type, Print) Peter Arthur Peltier (Spouse) 19b. Mailing Address (Street and Number or Rural Rou 12221 Bradbury Dr. Gaith	ute Number, City or Town, State, Zip Code) nersburg, MD 20878
20a. Method of Disposition Comparison of	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility De Vol 10 East Deer Park Dr.	Funeral Home Gaithersburg, MD 20877
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the mode of dying, such as cardiac or respondent on the content of the conte	Approximate Interval Between Onset and Death Onths
Sequentially list conditions, it arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): d.	=======================================
Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last Course (Disease or injury that initiated events resulting in death) Last	
Note to the past 12 months? 1	23d. Date of delivery Month Day Year
the discrete services and page 100 kmown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Very serious of the state of th	24a. Was an autopsy findings available autopsy performed? 1 □ Yes 2 No 1 □ Yes 2 □ No
To go a so a so referred to medical sexaminer? 25. Was case referred to medical examiner? 1	
1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Sea. Date of injury (Month, Day, Year) 28b. Time of injury at work? 27. Manner of Death 1 Nursing Home 5 Sea. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 1 Nursing Home 5 Sea. Date of injury (Month, Day, Year) 1 Yes 2 No	5 X Residence 6 Other (Specify) Describe how injury occurred
27. Manner of Death 27. Manner of Death 28d. Date of injury 28d. Time of injury 28d. Date of injury	ocation (Street and Number or Rural Route Number, ity or Town, State)
25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 28b. Time of injury 28b. Time of injury 28c. Injury at work? (Month, Day, Year) 28c. Injury at 1 Yes 2 No 28d. Date of Injury 28d. Date of inju	me date and place, and due to the cause(s) and manner stated
29b. Signature and title of certifier 29c. License number D17912	29d. Date signed (Month, Day, Year) September 20, 2012
30. Name and address of person who complete cause of death (Item 23a) (Type, Print) Dr. Judith E. Karp M.D. 1650 Orleans Street CRB 1, Baltis	more, MD 21231
State Registrar SEP 2 5 2012 (Month, Day, Year) 32. Registrar's Signature A. January B.	-,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Edward Bradley September 2012 12:30am Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Village Health Care Center Montgomery Montgomery Village If Under 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 27 If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Year 19<u>30</u> Months Hours Min **Director** Arkansas 431-36-9953 82 Jan. Usual Residence of Decedent 28a-f shov 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Montgomery Village ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be with 1 23a Funeral 20427 Remsbury Place 20886 United States items within 72 hours after death 11. Marital Status 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1948ò δ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates. 2 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" Completed 3 Widowed 4 X Divorced 1952 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Federal Government Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ပ Roland Bradley Dora McAnally 19a. Informant's Name/Relationship (Type, Print) (Significant Jacqueline Elder Other) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Elder 20427 Remsbury Place, Montgomery Village, MD 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 9/25/2012 Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ End Stage Renal Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed Hypertension attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Li retai don
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Dav Year the 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: Certificate: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🛮 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending

Registrar DHMH 17 Rev 7/2009

State

15+1

To the Hospital o within 24 hours af

Medical

Accident Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dr. Vinu Ganti, M.D.

3 Suicide
4 Homicide

29a. Certifier

(Check

Investigation

determined

6

NP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

Division of Vital Records, P.O. Box 68760

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

19529 Doctors Drive,

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Germantown, MD 20874

29c. License number

D41162

🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

September 24, 2012

City or Town, State)

		State of Maryland / Department of Health an Certificate of Death	, ,	giene leg. No. 2012 33200
Physi	ician edica	1. Decedent's Name (First, Middle, Last) Jacob Gerson BEHRMAN	2. Date of Deat	
Exar			Death	4c. County of Death Montgomery
Funer Direct	or	5. Social Security Number 065-18-1024 Usual Residence of Decedent 6. Sex 1 X M 2 \square F 91 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Months Days Hours M	Min. 8. Date of Birth (Month, Day, July 10	Year) Country)
faryland 8a-f show ufied at				10d. Inside City Limits 1 ☐ Yes 2 🂢 No
with the M 23a or 28 ust be not		10a. State 10b. County 10c. City, Town or Location Bethesda 10e. Street and Number 9707 01d Georgetown Rd. #3231 10f. Zip Code 20814 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origins 14 Was Decedent of Hispanic Origins 15 Was Decedent of Hispanic Origins 16 Was Decedent of Hispanic Origins 16 Was Decedent of Hispanic Origins 16 Was Decedent of Hispanic Origins 17 Was Decedent of Hispanic Origins 18 Was Decedent Origins 18 Was Decede	1	log. Citizen of What Country?
)036 Irs after death Lexaminer m	1 	1 Never Married 2 Married 1 Yes 2 No	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036 sernit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at		3 Widowed 4 Diovorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Publisher	r working	16b. Kind of Business/Industry Behrman House
yland Id be filec Mental H Rarked ott	Ę	_ ioi motifici o	s Name (First, Middle, M ara Diamo	aiden Surname) Ond
Baltimore, Marylar permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ex		19a. Informant's Name/Relationship (Type, Print) Jeffrey Sherman, son in law 19b. Mailing Address (Street and Number or 7902 Paloma Ct., Bet		City or Town, State, Zip Code) 20817
IMOre Page 1 a ment of H ant: If ite		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Dotse (Specify) 20b. Place of Disposition (Name of Ohever Shatton of Phat. Synagogue Cemetery September 1.5		20c. Location - City or Town, State Washington, DC
Balt permit. Depart Import any inj	ouce.		Torchinsky	Hebrew Funeral Home
Ph sicia		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	diac or respiratory arres	st, Approximate Interval Between Onset and Death
Medic Examine	er	Due to (or as a consequence of): Aortic Stenosis		
cuted and transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Emphysema		=
rou cate be executed physician and s the burial-transit				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burnal-transit	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months?		23d. Date of delivery Month Day Year
res that th signed by	2	rear ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to the cause of death?
e law requires has been sig ge 2 should k	Completed		24a. Was an	24b. Were autopsy findings available prior to completion of cause of
Physician: The law rthis certificate has	Be	25. Was case referred to medical examiner? 1 Vers 2 Value Hospital: Other:		
iding Phy th. After this funeral c	cate: To	1 I impatient 2 II En/Odipatient 3 I DOA 4 I Nursin	28d. Describe hov	nce 6 Other (Specify) vinjury occurred
of or Atter after dea Director d in by th	Certificate:			eet and Number or Rural Route Number, State)
ne Hospita n 24 hours ne Funeral	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and	red at the time, date and	place and due to the cause(s) and manner stated
504		29b. Signature and title of certifier D 37059	29 S	d. Date signed (Month, Day, Year) ept. 24, 2012
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey Sherman , MD 2021 K St., NW, #401, Washingt	ton, DC 200	06
St Regis	tate trar	31. Date filed (Month, Day, Year) SEP 2 6 2012 SEP 2 6 2012		

Provision Medical Provision From teaching and data and companies of the co				State of Mary State Amended #20b.perfuneral	rland / Department of Health and N home / 12/2/12/12/04/14/14 home / 12/2/12/12/04/14	Mental Hygiene
Examination Formation			11cgista	Germicate of Beauti	2. Date of Death 3. Time of Death	
Transcript Transc				KITA BRAXTON		SATEMBER 26,2012 4:27 PM
To State 1		Funeral	er	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foleign Country)
Office of the control				Usual Residence of Decedent	6	
Office of the control		ryland I-f sho ied at	ctor			
Office of the control		he Ma or 28a e notif	Dire	Maryland Anne Arundel 10e. Street and Number		10g, Citizen of What Country?
Office of the control		s 23a uust be	neral	1931 Arwell Ct	21144	454
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Modical Examiner Modical Exa			Г	28a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.		or respiratory arrest, Approximate Interval Between
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State 31. Date filed (Month, Day, Year) 32/Registrar's Signature 2		ŏ ∓ ҳ н ,		1 Mule		
State 31. Date filed (Month, Day, Year) 32/Registrar's Signature 2		60-6		30. Name and address of parson, who completely cause of death BALTIMONE WASHINGTION	* (Item 23a) (Type, Print) 301 HOSPITML MEDICAL CENTER,	OUR BURNE MD 21061
				31. Date filed (Month, Day, Year) 32 Registrar's S	Signature 2	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Danny L. Braithwaite Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Hospital Cumberland Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days 232-29-7225 Director 1 M 2 □ F 26 10-15-1985 MD or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits WV Mineral Piedmont Y☐ Yes 2 ☐ No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 99 Second St. 26750 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Danny L. Braithwaite Sandra Guthrie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nicole Braithwaite Wife 99 Second St. Piedmont, WV 26750 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Crem. Cresaptown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fredlock F.H. Piedmont, Jones St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last to (or as a consequence of) Certificate: To Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed?. Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours a To the Funeral C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year, gess of person who completed cause of death (Item 23a) (Type, Print) noman

■ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For		State of M	arylar			Health and	Mental H	ygiene		-	000	0.0
		State Registrar				Cert	ificate of	Death		Reg. No	<u>. 201</u>	2	332	UJ
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Director		Usual Residence of Decede] M 2 X F	76	Yrs.	Working Bay	3 Hours Will			1935	Journey)	NC	
and show	'n	10a. State 10b. Co			10c. Cit	ty, Town or Loca	ition		4		<u> </u>	10d.	. Inside City Li	mits
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	4034 E	541	erf, 5	Everially	S 12 W		019	Specific Veneral Na		U,		,	
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Physician/		Immediate Cause (Final disease or condition	LIST ONLY ONE	cause on each line	1/1		0000						terval Betweer nset and Death	
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th cer ttendl or use	ian/	23b. Was decedent pregnant in the past 12 months?	23	Bc. If yes, outcome 1 Live Birth	2 Feta	al death 3 🔲 E				- 0	23d. Date of	-		
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the H hin 24 the F mplet		only one) 3 L Certif	fying Nurse	Practitioner: To the	e best of n	ny knowledge, de	eath occurred a	nion, death occurred t the time, date and	place, and due to	the cause	(s) and manne	as state	ed.	stated.
To COI		29b. Signature and title of cer	tifier	Toda	was	am pr		ise number	2		te signed (Mor		Year)	
	-	30. Name and address of per-						74168						
		30. Name and address of per	3000d	inpleted cause of de	eath (Item	+ Suite	2 1363	s Balti	more 1	10	212	31		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Priscilla G. Brown not institution, give street and number 4c. County of Death lishuru onico . Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Country) 213-20-9407 1 🗆 M 2 🗶 F 87 12/01/1924 Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🙀 No Maryland Worcester Ocean City 10e. Street and Number 10g. Citizen of What Country? 115 135th Street 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 X Married 1 Yes 2 X No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Clerical Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Landon Edith M. Welling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William S. Brown/Spouse 115 135th St., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/25/2012 Salisbury Crematory Salisbury, MD 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill , Salisbury, MD 21804 Rd 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death air ho sis disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE:

Examiner and attending physician for use as the buria The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 been signed by the s has To the Hospital or Attending Physician: eral Director: After this filled in by the funeral di

Exami Physician/Medical Completed by Be 은 Certificate:

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mus

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Medical **Examiner**

in the past 12 months? 1 Yes No 9 Unknown	23d. Date of delivery Month Day Year								
Part II. Other significant conditions	contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown						
			24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 2 ☐						
25. Was case referred to medical examiner?		26. Place of Death (Check only one)							
1 ☐ Yes No	Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Other: 4 Nursing Hor	ne 5 - Residence "State" (Specify) We Spice						
7. Manuer of Death Natural 5 Pending 2 Accident Investigat		e of 28c. Injury at 2	28d. Describe how injury occurred (XL)						
3 ☐ Suicide 6 ☐ Could no determine	200 Dioce of Injury At home form	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier Certifying Pl (Check 2 Medical Exa	ysician: To the best of my knowledge, deaniner: On the basis of examination and/or in	ath occurred at the time, date and place, an ivestigation, in my opinion, death occurred at	d due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s) and manner stated.						

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c, License number D63199

EASTERN SHORE DR., SALISBURY MD. 21804

22/12

Registrar DHMH 17 Rev 06-2011

State

24 hours a

ress of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

910

DHRA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 Kenneth Paul Bonneville, Sr. 0430 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll 2603 Manchester Rd. Westminster 7. Age (In yrs. last birthday) If Unde Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours **Director** 213-32-3870 1 🔀 M 2 🗆 F Yrs. 75 Dec 16, 1936 Maryland Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Carroll Westminster 10e Street and Number o 10g, Citizen of What Country? Funeral ["natural", or items 23a 2603 Manchester Rd. 21157 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Inforcant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give ₩Widowed 4 Divorced Completed White Year or Dates Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Wire Assemblyman Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edna Naomi Beale Louis James Bonneville, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Bathurst Rd. Catonsville, MD 21228 Kim Bryan/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/2012 | West Friendship, MD Crestlawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Pritts Funeral Home & Chapel, PA Signature of Funeral Service Li 412 Washington Rd., Westminster, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres 23a. Part 1. Enter the disease, or complication Approximate ch line shock, or heart failure. List only one caus Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury utile to for as a nonsequence offi To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No Month 1 Yes 2 L 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an cate has t autopsy performed? Yes 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify this 28a. Date of injury (Month, Day, Year) Certificate: Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After injury Natural 5 Pending Accident Investigation within 24 hours after death To the Funeral Director; A completely filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

Registrar

State

Medical

29a. Certifier

(Check 29b. Signat

and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nutse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Albert Bowens Month Medical October 6 2012 8:05 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day Year) Dec. 17, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Days Hours Mary Land Director 213-74-6834 1 XM 2 □ F 55 1956 should be filed within 72 nouse amount of the stand Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show are the standard of the Medical Examiner must be notified at 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Frederick Frederick 1X Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 Thomas Avenue 21701 United States 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 ☐ Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Never Worked Not Applicable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James O. Thompson Peggy C. Bowens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Dawn Ann Bambrick (Personal Rep. 2090 Old Farm Dr. Suite 1E, Frederick, MD 21702 20a. Method of Disposition
1 ☐ Burial 2 🗡 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place, Smithsburg Crem. 4 Donation 5 Other (Specify) 10/9/2012 Smithsburg, Maryland 21. Signarare of Funeral Service bicenses 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
100 E. Church St., Frederick, MD 21701 MO1612 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or, each line. Approximate Interval Between Immediate Cause (Final Physician **Onset and Death** disease or condition Medical resulting in death) Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached it Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🚺 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) ျှ 1 Yes 2 No Other: 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bush Irai

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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niner	4a. Facility Name (if not institution, gi 609 ZAIDEE LANE	ve street and number)		4b. City, Town, or STEVENS		Death			c. County of Death QUEEN ANNE'S				
al		Sex 7. Ag	ge (In yrs. last bi	rthday)	If Under 1 Year Months Days	If Under 24	Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign		
r	281-18-5925 Usual Residence of Decedent	1 X M 2 □ F	88	Yrs.	Widitins Days	Tiours I	WIIII.	JAN. 28		OH	**		
ğ	10a. State 10b. County		10c. City, Tov	wn or Lo	cation						10d. Inside City Limits		
irec	ID QUEEK MINE C CILIVENOVIEED										1 🗆 Yes 2 🛣 No		
ra D	10e. Street and Number 609 ZAIDEE LANE	10e. Street and Number					10f. Zip Code 10g. Ci						
Funeral Director	11. Marital Status						? (Spec	cify Yes or No- Rican, etc.)	USA 14. Ra	14. Race - American Indian,			
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	8	-0-		ATS	AIN MATE	FIRST	CL	ASS	UNITEI	STA:	TES NAVY		
To Be	17. Father's Name (First, Middle, Last							(First, Middle, M		ne)			
	19a. Informant's Name/Relationship		10	lb Mailin	ng Address (Street a			H McCLEI		.UGH v or Town, State, Zip Code)			
	QUENTIN OSCAR CU				MEADOW ROA						odde)		
	20a. Method of Disposition 1 XX Burial 2 Cremation 3 4 Donation 5 Other (Spe		20b. Place cemet	of Disponence of Disponence of Circles of Ci	sition (Name of natory or other place I NATIONA I'ERY	L UN	KNO		20c. Location	-	own, State VIRGINIA		
	21. Signature of Funeral Service Lice	Duk	2	F F	Name and Addres CLLOWS, HE	s of Facility LFENBE	IN 8	& NEWNAN	1 FUNEE	RAL HO	OME, P.A.		
Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MELANOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of):												
i ilyalolali/inicalo	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown No Security Ves 2 No 9 Unknown Unknown 1 No Security No								23d. Date of delivery Month Day Year				
Dy F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobac							acco use con	co use contribute to the cause of death?				
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oci micare.	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	(Month, Da	y, Year)	injury		aτ /es 2□No			ribe how injury occurred				
								State)					
Medical	(Check 2 📖 Medical Exar	ysician: To the best of niner: On the basis of e irse Practitioner: To th	examination and/	or investi	igation, in my opinior	 death occur 	red at the	he time, date and	place, and du	e to the ca	use(s) and manner stated		
	29b. Signature and title of confifier				29c. License	number			octobi	d (Month, i	Day, Year)		
	30. Name and address of person who					NTREVI	LLE,	, MD 216	517				
te ar	31. Date filed (Month, Day, Year) OCT -1 20	32. Registra	ar's Signature										
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DHMH 17 Rev 06-2011

Maryland 21215-0036

Baltimore.

Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1200pm Physician/ Month Day Edna 28 201 september Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Boutimore HOSPITAL The Johns Hopkins 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 02/15/1942 Country) 219-58-7651 Director 1 M 2 XF MD 70 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1¥ Yes 2 □ No St. Mary's Lexington Park MD 10g. Citizen of What Country? USA or 10e. Street and Number 10f. Zip Code 20653 23a Funeral 46543 Valley Court #5005 "natural", or items edical Examiner mu death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes If Yes, Give 2 X No Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+ Private Homemaker Be 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname) Agnes Moreland James N. Holt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O.Box 1582 Lexington Park, MD 20653 Barbara M. Holt / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Charles Manorial Cardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10/04/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Briscoe-Tonic Funeral Home 21. Signature of Funeral Service bicerse 2294 Old Washington RD Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live Birth 2 ☐ Fetar deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Month Year signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown been sig Completed 24a. Was an Were autopsy findings available prior to completion of cause of Sec page 2 autopsy perform death? certificate Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending 1 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month

Registrar's Signat

1800 Orteans st. Barto. md 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09/22/2012 SOO IL CHUNG 14:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Country) 364-38-4297 **Director** 1.XDM 2 □ F 12/21/1934 Korea Usual Residence of Decede "natural", or Items 23a or 28a-f sho 10c. City, Town or Location within 72 hours after death with the Meryland 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6839 Old Stage Road 20852 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Mamed 2 XMamed <u>۾</u> Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Korean 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years Biochemist Medical Research Ith and Mental Hygie 27 Is marked other r traumatic event, II Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Kyui Nyu Yoon permit. Page 1 end 2 should be Department of Health and Men Important: If Item 27 is marke any Injury or other traumatic. once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yoomie Chung/wife 6839 Old Stage Road, Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cremation Center MD 09/25/2012 | Hanover, MD Signature of Funeral Servi 22. Name and Address of Facility Snowden Funeral Home M101576 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ Ischemic Colitis disease or condition Medical resulting in death) Due to (or as a consequence of): Peripheral Vascular Disease Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, keeling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24a. Was an 24b. Were autopsy findings available autopsy performed Yes 2 prior to completion of cause of death? 1 Yes 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 14 Natural 5 Pending Division 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar Melissa Means,

31. Date filed (Month, Day, Year)

SEP 25

DHMH 17 Rev 06-2011

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8600 Old Georgetown Road, Bethesda,

MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signatu

MD

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1 - State Registrar						Certificate of Death					Reg. No. 20 2 332					211			
	Decedent's Name (First, Middle, Last) Physician/ Physician/								2. Date of I					O: THIRE OF DEGILE					
	Pnysicia Medic	M C										Month Septemb	er :	$\frac{1}{2}$	ear 12	2.11	рм		
	Examin		4a. Facility Name (if n	ot institution, give	street and numbe	r)		4b. City,	Town, or I	Location o			\neg	c. County of					
			Holy Cros	s Hospit	a1			l Si	1ver	Spr	ing		Montgomery						
	Funeral		Social Security Nur	mber 6. Se		Age (In yrs. I	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Birt	:h		Birthplace (State or Foreign				
	Director		212-04-21		□м Ж ХХТ F	44	Yrs.	Months	Days	Hours	Min.	(Month, Da)		160	Coun	**			
	T		Usual Residence of			1						Feb. 19	, 15	700		yland			
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	28a	ire	MD		gomery	S	ilver	Sprin	g							1 🗌 Ye	s 21K No		
	h the	a [10e. Street and Numb					10f. Zip	Code				10g. C	itizen of Wh	at Coun	try?			
	h wit	Funeral Director	718 Richm	ond Ave.					2	0910			Ι	JSA					
	deat iten		11. Marital Status		 Was Deceder Armed Force 		3. 13.	Was Decede If Yes, speci	ent of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race -					
36	after ", or	by	1 Never Marrie		1 ☐ Yes 2 ² If Yes, Give	No No	i i	1 ☐ Yes 2				, , , , ,		Specify: h	White, e	AC.			
8	ours Itura	Completed	3 Widowed 4	S.															
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₫	t. Part tmer tant jury			5 Other (Specif	<u> </u>		C	remate	rv	i	Берс			xandr:		VA			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination of the realist of any once.		21. Signature of Fund	ral Service Lice A	ates		F	rancara 00 Uni	Address Lvers	of Facility	lins Blvd	Funera . W. Si	l H	ome In	nc.	MD 2	0001		
			23a. Part 1. Enter the	e disease, or comp	lications that caus	sed the death								r ppr.	riig.	Approxima			
	Priysician/	10	snock, or retart failure. List only one cause on each line. Interval Betwee										tween						
	Medical		disease or condition resulting in death) Pulmonary Edema Due to (or as a consequence of): Pneumonia																
	Examiner																		
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2097	icate g phy is the	ed			u														
Vital Records, P.O. Box 68	aw requires that the death certific as been signed by the attending i 2 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent p	regnant	23c. If yes, outcom	ne of pregna	ncy	7						23d. Date	of delive	in/			
õ	eath e atte d for	icia 	in the past 12 mg		1 ☐ Live Birt 4 ☐ Pregnan	t at time of d		□ Ectopic parallel □ Other (specified)						Month					
	the d by the ache	<u>چ</u>	9 Unknown		9 Unknow	n													
٦. ک	that hed b	اج	Part II. Other signific			h but not res	ulting in the u	ınderlying ca	ause give	n in Part I		23e. Did to	bacco	use contribu	rte to the	e cause of c	death?		
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Division of	after after Dire	ပ္ပြု	4 ∐ Homicide	determined		etc. (Specify)		oct, ractory,	Onico		ľ		Bf. Location (Street and Number or Rural Route Number, City or Town, State)				uer,		
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has is completely filled in by the funeral director, page 2 s.	<u>ica</u>	29a. Certifier 1	Certifying Phys	ician: To the best	of my knowle	edge, death	occurred at	the time	date and	place an	d due to the ca	use/s) s	nd manner	as etato				
	e Hc e Ful e Ful	Medical	(Check 2 L	☐ Medical Exami ☐ Certifying Nurs	ner: On the basis o	f examination	and/or invest	tigation, in m	noiniao vi	. death occ	curred at	the time, date an	nd place	and due to	the cau	se(s) and ma	anner stated.		
	Withir Comp	<	29b. Signature and titl		0	1	.,smouge,		License r		- and plat			te signed (A					
			> dm	11010	6/1	ACIO	On. L	·əl	DET	7620				ept. 2					
	رب ا	ŀ	30. Name and address	s of person who o	ompleted cause of	f death (Item	23a) (Tivne 5	Print)	וכע	7630_				ept. A	.0,	2012			
			Anuradha						ad, S	Silve	r Sp	ring, M	D 2	0910					
	Stat		31. Date filed (Month,				ure fau												
	Registra	r	OCT	01 2012	Senus	J. 1.	MAN	1											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, Physician/ 12:40 AM Shirley Ann Clark September 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4714 Rockford Drive Prince George's Hvattsville If Under 1 Year If Under 24 Hrs. Hours Min. Social Security Number Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 217-42-1024 Director 1 □ M 2 🖾 F 67 Yrs June 12, 1945 Riverdale, Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Hyattsville 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or death with Funera 20784 USA 4714 Rockford Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home the Homemaker 12 event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) age 1 and 2 should be filed on the filed of Health and Mental H It: If item 27 is marked ot y or other traumatic even 2 Vincent George Hahn Jeanne Crowe Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Jeanne Herbert / Daughter 4714 Rockford Drive, Hyattsville, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 9/28/2012 Fort Lincoln Cemetery Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Liver Cancer disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death Unknown the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ð page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 1 ☐ Yes 2 🖾 No 1 Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 🔀 No Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 d title of certi 29b. Signature a 29d. Date signed (Month, Day, Year) D32261 9/26/2012

State Registrar

DHMH 17 Rev 06-2011

15 TM

Richard Jay Feldman, M.D., 8116 Good Luck Road, Suite 300, Lanham, MD 20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

12-07180 Kyle Anthony C	alav	retinos State	or Print in Black of Maryland / De	epartment o	f Health and			egible		2 332			
Dh:		1- For State Registrar 1. Decedent's Name (First, Middle,La		Certificate o	f Death			Reg. No.	2 U i				
Physici Medical Exam			•				2. Date of De Month Septemb		Year	3. Time of Death 1214 hrs			
		4a. Facility Name (if not institution, gi	ve street and number)		4b. City, Town, or				County of Death	1			
		5222 Tilden Rd			Bladensburg				rince George				
Funeral Director		5. Social Security Number 6. S 219-29-8593 1 2		yrs. last birthday) 21 Yrs	If Under 1 Year Months Days		Ain. Novembe		Foreig	thplace (State or on Washington, untry) D(
any .			10d. Inside City Limits										
.	_	Maryland Prince Coorgo's Pivordale Book											
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number			10f. Zip Code			10g. Citize	en of What Cou				
the M									USA				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1											
hours natur Exami	edt	15. Decedent's Education (Specify of	nly highest grade complete	d) 16a. Deceder	nt's Usual Occupati	ion (Give kind o	of work done	16b. Kii	nd of Business/I	ndustry			
Baltimore, MD 21215-0036 ormit. Pages I and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical I.	Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) 12 Coach Cleaner Amtra											
of filed at Hyg	Be C	17. Father's Name (First, Middle, Last Joseph Oliver Ca	•		1		me (First, Middle, cilia Me						
212 buld b	ToE	19a. Informant's Name/Relationship (19b. Mailing	Address (Street					Zip Code)			
MD d 2 sh lth and a 27 is		Virginia M. Steele / Aunt 11450 Log Ridge Drive, Fairfax, VA 22030											
or Lean of Heal If item		20a. Method of Disposition 1 Burial 2 X Cremation 3		Ob. Place of Dispos crematory or oth		· 1	Date	1	ocation - City or				
imc Page ment o		4 Donation 5 Other Specify		Metropolita	n Cremator	у 9.	/28/2012	Ale	xandria	, Virginia			
Balt Permit Depart Impor		21. Signature of Funeral Service Licer	see		lame and Address	•	D 4	4739	Baltin	nore Avenue			
Physician	\dashv	23a. Part Enter the disease, or comp	plications that caused the de	eath. Do not enter th	SCN S FUR	such as cardia	ome, P.A.	Hyat rest. shock	k. or heart	, MD 20781 Approximate Interval			
/Medical Examiner		failure. List only one cause on ea	ach line. Intraoral Shotgun W Due to (or as a consequence	ound						Between Onset and Death			
	Examiner	Sequentially list conditions, b.											
		if any, leading to immediate — Due to (or as a consequence of): cause. Enter Underlying Cause City											
ed nsit	Xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):									
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760, icate be execut physician and the burial - tra	ğ	UNPENDED	AMENDED										
, P.O. Box 68760, res that the death certificate be execut signed by the attending physician and be detached for use as the burial - tra	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	c. If yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnanc Pregnant at time of death 5 Other (Specify)					23d. Date of delivery Month Day				
BO) e deatl the att	hys	1 Yes 2 No 9 Unknowr	9 Unknown										
that th	된 B									contribute to the cause of death?			
Guires en sign	ted	1											
cords, law requir has been s	Completed						24a. Was	osy	prior to co	opsy findings available empletion of cause of			
tal Reco	5							rmed? 2 ✓ No	death?	2 No			
Vital ysician: his certifi director,	8	25. Was case referred to medical examiner?	lospital: 1 Inpatient 2	CD/Outration		of Death (Chec		-	م اتقام،				
n of Viding Physical After this funeral dir	<u>۽</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 28b. Time of In					e 6 Other:	Scene			
Sion Atten r death rector: by the	Certification:	1 Natural 5 Pending Investigation	liury 28c. Injury at Work? 1 Yes 2 № No 28d. Describe how injury occurred Subject shot self t, factory, office building, etc. 28f. Location (Street and Number or Rural Route					al Route Number City					
Divi	팋	3 ✓ Suicide 6 Could not determined	be		., .20tory, ontoe bu		or Town, S 5222 Tilden R	State)		ai noute mumber, orty			
Hospital 24 hours Funcral		29a. Certifier 1 CertifyIng Physici	an: To the best of my know	ledge, death occurr	red at the time, date	e and place, ar	nd due to the caus	se(s) and r	manner as state	d.			
To the How within 24 h To the Fur completely	Medical	one) 2 Medical Examiner	On the basis of examination	on and/or investigati	on, in my opinion,	death occurred	at the time, date	and place	, and due to the	cause(s)			
	Ž	29b. Signature and title of certifier			29c. License			29d. Da	te signed (Moni	h, Day, Year)			
.5		シーン .			O.C.M	I.E.		Septe	mber 24, 20	12			
N: 15	- 1	20 Name and address of parson who		· · · · · · · · · · · · · · · · · · ·									

State Registrar

31. Date filed (Month, Day Year)

OCME

32. Registrar's Signature

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 26 2012 1:05 A M Thomas Lee Cornish Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico Nursing Home Salisbury Wicomico 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** Davs Hours (Month, Day, Year) Director 215-20-2111 1 🔀 M 2 🗆 F 11 04 1927 Maryland 84 Usual Residence of Decedent 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Mental Hygiene. ant If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits r than "natural", or Items 23a or 28a-f sho the Medical Examinar must be notified at Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21801 612 Hill Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates. Army 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me any Injury or other traumatic event, the Me and Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) Health Department Health Investigator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Pauline Stewart Thomas Wilson Cornish 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Hill St., Salisbury, Maryland 21801 Alexine Cornish|wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Springhiil Memory 10 02 2012 Hebron, Maryland Cardens 21. Signature of Funeral Service Dicensee Stewart Funeral Home by Holloway and Downey PA CESP 821 West Rd., Salisbury, Maryland 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Diskitis Physician/ disease or condition One month Medical resulting in death) Due to (or as a consequence of): Examiner Endstage Renal Discore 5 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events ASCVA Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1√ Yes 2 No Hospital Other: ္ 1 Inpatient 2 ER/Outpatient 3 DOA W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number who rah Do51359 September 28/5 20/2 DIC 119 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 957. Mount HURMON ROAD, SALISBURY, MD 21804 DR USHA NATESAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of iviaryland		tificate of D			Reg. No. 2	12	33215		
	Physicia		1. Decedent's Name (First, Middle, Last) Virginia	Donis	5			2. Date of Dea	th 24, ^{Da} 201:	2 Year	3. Time of Death 7:45p M		
1	Medic Examin		4a. Facility Name (if not institution, give str Althea Woodland	ome	4b. City, Town, or	Location of Death		4c. County	of Death	erv			
	Funeral Director		5. Social Security Number 6. Sex 106-36-3005	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl	n	9. Birthp	place (State or Foreign		
and 21215-0036 be filed within 72 hours after death with the Maryland	laryland 3a-f show ified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Montgome		Town or Local	sation Spring				1	0d. Inside City Limits		
	with the M 23a or 28 ust be not		10e. Street and Number 1000 Daleview D	rive		10f. Zip Code 2090)1		10g. Citizen of U	What Cour	try?		
	ould be filed within 72 hours after death with the Maryland od Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	٥	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	- 1	Vas Decedent of His f Yes, specify Cuban			Blac	e - Americ ck, White, e : Whi	etc.		
Maryland 21215-0036	thin 72 hou ene. than ''nat i he Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	(Give I	lent's Usual Occupa kind of work done di O NOT use retired) eamstres	uring most of work	ing	16b. Kind of Business/Industry Clothing					
and 2: be filed wit	be filed wi lental Hygis rked other iic event, t	To Be (17. Father's Name (First, Middle, Last) unknown		18. Mother's Name (First, Middle, Maiden Surname) unknown								
, Mary	2 sh har 7 is trau		19a. Informant's Name/Relationship (Type, Antonio Barreto/			g Address (Street at 75th Av							
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other 1 once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crem. 9/26/2012 Beltsville, Md.										
Bail	permit Depart Import any in		21. Signatur / Funeral Service Consee	2i		Timer Addes					,P.A. ,Md20910		
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A LIMES Due to (or as a consequence of):									RS C	Approximate Interval Between Onset and Death		
	ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque									
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. Box 687	death certif ne attending ed for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	Was decedent pregnant n the past 12 months? ☐ Yes 2 ▼ No 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									
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Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detach	omplet	Lopus Englinematrois AWOMIA 1 Yes 2 No 3 Probably 4 1 24a. Was an autopsy performed? 1 Yes 2 No										
Vita	rsician: The law rs certificate has b	To Be C	25. Was case referred to midical	spital:	B/Outpatier	_ Other	ce of Death (Chec	k only one)					
on of \	anding Physath.	Certificate: T	1 Impatient 2 II En/outpatient 3 II DOA 4 M Nursing nome 5 II nesidence 6										
Divisi	ital or Atterns after de al Directo		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	eet, factory, office	y, office 28f. Location (Street and Number or Rural City or Town, State)				Route Number,				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director.	Medical	(Check 2 Medical Examine)	an: To the best of my knowle : On the basis of examination Practitioner: To the best of my	and/or invest knowledge,	igation, in my opinior death occurred at th	n, death occurred a e time, date and p	t the time, date ar ace, and due to th	nd place, and du ne cause(s) and r	e to the cau nanner as s	use(s) and manner stated. tated.		
	년 <u>홍</u> 년 8		16 Eullen	pleted cause of death (item 2 32 Registrar's Signatu	2	DC C	01852	. 5	29d. Date signe	is (ivioritin, i	5 2c 12		
			30. Name and address of person who com	ipieted cause of death (Item 2	23a) (Type, F	eersbu	my Co	Hat	Suille	Mis	20201		
	Stat Registra		31. Date filed (Month, Day, Year) SEP 2 6 2012	32 Hegistrar's Signatu	· pa	del.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ BARBARA JANE DEMAR 09/26/2012 5:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice Casey House Rockville Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 216-72-1728 Director 1 🗆 M 2 🗓 F 01/29/1960 MD 52 and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1🏋 Yes 2 🗌 No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20850 USA 307 Dawson Avenue 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, by 1 X Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food 12th Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Virgie Warren Richard Cunningham traumatic Department of Health an Important: If item 27 is n any injury or other traum once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Dawson Avenue, Rockville, MD 20850 Chester Hill/companion Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)MD 1 Burial 2 K Cremation 3 Removal from State Cremation Center of 4 ☐ Donation 5 ☐ Other (Specify) 10/01/2012 Hanover, MD 21. Signatur Funeral Service Line Snowlen Funeral Home 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar as the buri Physician/Medical Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 XNo Dav Pregnant at time of death 5 Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 Yes 2 No 1 🗌 Yes 2 💢 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pendina ithin 24 hours after death.

the Funeral Director: Aformpletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 09/26/2012 D37142

DHMH 17 Rev 06-2011

Registrar

State

1355 Piccard Drive, Rockville, MD 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman, MD

OCT 01 2012

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

Physician/ Medical Examiner Funeral Director Plant a Facility Name (if not institution, give street and number) 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Month Sept. 30, 2012 8. Sept. 30									
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autopsy prior to completion death? 1 □ Yes 2 ☑ No	- cause of								
25. Was case referred to medical examiner?									
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27. Manner of Death 1 Natural 2 Accident 1 Natural 3 Suicide 4 Homicide Homicide Suicide Accident Homicide Accident Homicide Accident Homicide Accident Accident Homicide Accident Accident Homicide Accident Homicide Accident Accident Homicide Accident Homicide Accident Accident Homicide Accident Accident Homicide Accident Accid									
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Second Contribution									
Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	manner stated.								
29b. Signature and title of entifier 29c. License number 29d. Date signed (Month, Day, Year)									
172969 10/3/12									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sofiere Savapoulos 255 N Fourth Steet, Suitel Oakland, MD 21550									
State 31. Date filed (Month Por Year) 4 2012 32. Registrar's Signature,									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Othe 200m Medical 4a. Facility Name (if not institution, give street and number) 8511 Bonny Drive **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Forestville Prince George's Social Security Number * Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Sept 24, If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 578-46-1706 77 Days Day, Director 1 🗆 M 2 🗔 1934 Washington Usual Residence of Decedent works 10a. State at 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f Maryland Prince George's Forestville 1 X Yes 2 □ No 10e. Street and Number ō 10f. Zip Code ms 23a or must be n 10g Citizen of What Country? Funeral 8511 Bonny Drive 20747 United States permit, Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 □ Divorced **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Dental Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Henry Barton Mary Louise Suddreth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Freda Barton-Haleem/Sister 4609 Miller Drive Durham, NC 27704 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Nat'l Mem Pk 1 X Burial 2 Cremation 3 Removal from State Sept 29, 2012 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4001 Benning Road, NE Washington, DC 20019 M00560 Cowall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on sach line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Esquantiany list to diffusis, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phase as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed' certificate 2 🗌 No Yes 2 1 No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 1 Yes 2 100 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 **To the I** only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year)

ME

State Registrar erson who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

2001

Cas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Raymond W. Donahoe Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death NICOMICO MEDICAL KIGIONAL SAX | 5041 m Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-20-1933 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 218-28-3350 Director 1 XM 2 F 79 Maryland permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If Item 27 is merked other than "natural", or Itema 23a or 28a-1 show any Injury or other traumetic event, Ital Maryland Italians any Injury or other traumetic event, Ital Maryland Italians at any Injury or other traumetic event, Ital Maryland Italians at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director SnowHill 1 K Yes 2 □ No Worcester 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 430 W. Market Street 21863 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Yes 2 No If Yes, Give Army Black, White, etc. 1 K Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Packer Packaging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Henry Donahoe Cathline Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Felix Donahoe (Brother) 32782 Bi-State Blvd. Laurel. 19956 De. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva! 9-28-2012 4 Donation 5 Other (Specify) Delmar, Delaware Signature of Funeral Service Licensee 700 West Street 22. Name and Address of Facility Holly Hannigan Hannigan, Short, Disharoon F.H. Laurel, De. 19956 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Thorame Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Injury Due to (or as a consequence of): Exami The law requires that the death certificate be executed attending physician and for use as the burlel-trensit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day signed by the at id be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 I ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific, completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: |₽ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. \prec 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SRAVANTHY Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September ROSA 1634 2012 E. DOUGHTY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ROGIONAL REDINSULA SALISBYI NICOMICO MINICIPL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours (Month, Day, Year) Director 216-14-9938 1 □ M 2 💢 F 90 Yrs July 15, 1922 Maryland i Hygiana. I other than "natural", or items 23a or 28a-f show vent, the Medical Examinar must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 tv Yes 2 I No Pocomoke City Maryland

10e. Street and Number Worcester 10f. Zip Code 10g. Citizen of What Country? Funeral 1504 Cedar Street 21851 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Worcester County Elementary/Secondary (0-12) College (1-4 or 5+) Cafeteria Worker Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Paga 1 and 2 should ba filer tmant of Haalth and Mantal H tant: If Item 27 is marked of ည Arthur L. Blades Marie R. Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is eny injury or other treu Arthur L. Blades, Jr. (Brother 1504 Cedar Street - Pocomoke City, MD 21851 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Goodwill Methodist Cemetery 9/21/2012 Pocomoke, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure, List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) CORONARY ARTERY Medical Due to (or as a consequence of) Examiner CONGESTIVE HEART Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir nding physician and usa as tha burial-transit The law requires that the death cartificate be executed HYPERTENSIVE HEART DISEASE that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year baan signad by tha s should ba datachad 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ REGURGITATION 1 Yes 2 No 3 Probably 4 Unknown Completed REGURGITATION 24b. Were autopsy findings available prior to completion of cause of death? AORTIC 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Physician: funaral diractor, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ൧ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 Natural
2 ☐ Accident 5 Pending I Director: A 1 ☐ Yes 2 ☐ No after death Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in I in 24 hours to the Funeral Discomplataly fills Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9/19/12

DHMH 17 Rev 06-201

State Registrar

Box 68760

Records.

Division of Vital

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State 22 TO THE STATE OF TH						nd Mental Hy	giene												
		1 - State AMEND#23bperMD, 10/1/12; EMW, MbCo Certificate of Death Reg. No. 2012										33	222									
П	Physicia	an/	Decedent's Name (First, Middle	e, Last)		2. Date of Death Month Day Year September 25, 2012 1:25																
	Medi		Drew Eagle 4a. Facility Name (if not institution	give street and numb	erl		41- Oits Town	Landing of F		1	2012	1:25	av									
	Examin	ıer	Medstar Montgon		er	4b. City, Town, or Olney	Location of L	Death	4c. County Mont	of Death	v											
	Funeral		5. Social Security Number	ast birthday)	If Under 1 Year	If Under 24		h	9. Birthpla	ce (State or F	- oreign											
	Director		219-48-7221	1 🗷 M 2 🗆 F	65	Yrs.	Months Days	Hours	Min. (Month, Da)		Country)										
	how how	Director	Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Loc	eation		Dec. 12	, 1946	PA 10c	d. Inside City	Limite									
	larylar sa-fs ified		MD M	lontgomery	1		Spring				100	1 Yes 2										
	or 28		10e. Street and Number				10f. Zip Code			10g. Citizen of V	What Country	/?										
	s 23a	Funeral	724 Marblehed	ge Way			20905				USA											
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes, Give	es? X No	If	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 🛂 No	n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		e - American ck, White, etc Whit											
21215-0036	hours natura ical E	Completed	15. Decede	nt's Education	IS.	16a. Deced	ent's Usual Occupa	ation		16b. Kind of Bu	ısiness/Indu	stn/										
215	in 72 e. han "r Med	dmc	(Specify only higher (Specify only higher (Specify only higher (D-12)	est grade completed) College (1-4	or 5+)	(Give k	ind of work done do NOT use retired)		working	TOO. KING OF BE	13111633/11164	Stry										
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Maryland	ld be filec Mental H arked ot atic even	To Be		To Be								17. Father's Name (First, Middle, I	,	gle				Name (First, Middle, I		:)		
	nd 2 shou ealth and m 27 is m						19a. Informant's Name/Relations Diane Eagle/Si			. 1			r Rural Route Number 1 lver Spri n			de)						
Baltimore,	Page 1 ament of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		oto C	emetery, crem ropoli:	sition (Name of atory or other place tan ematory	Se	pt 26,	20c. Location -	•											
Balt	permit. Depart Import any inj		21. Signature of Funeral Service L	icensee 2 Oor	مكع	F22	Name and Addres		s Funeral			MD 209	01									
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cau	used the acath line.						A	pproximate										
	Physici_n/	8 1	Immediate Cause (Final disease or condition	a.	06	EDSI	2		,	,	0	nset and Dea	ath									
	Medical Examiner	L	resulting in death) Sequentially list conditions,	Due to (or	as a consequ	ente of):	rial	Per	ritoni	tis												
	p. 1	Examiner	cause. Enter Underlying Cause (Disease or injury) Cause (Disease or injury)																			
	icate be executed physician and as the burial-tensity	ы Еха	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ience of):	<u> </u>	7														
200	physic the p	edical	,	d																		
89	sertific nding use as	n/M	IF FFMALE: 23b. Was decedent p. e. a.	23c. If yes, outcome	me of <u>pregna</u> r	ncy				22d Dat	e of delivery											
P.O. Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tensity.	IF_EFMALE: 23b. Was deceden p 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II Other significant conditions contribution to death but not reculting in the underlying gaves given in Part II Other significant conditions contribution to death but not reculting in the underlying gaves given in Part II Other significant conditions contribution to death but not reculting in the underlying gaves given in Part II Other significant conditions contribution to death December 1 December 2 December 3 Ectopic pregnancy 1 December 3 December								Mor	-	ay Yea	r									
Θ.	s that gned l	by F	Part II. Other significant condition	ons contributing to deat	th but not resu	ulting in the ur	iderlying cause give	en in Part I.	23e. Did tol	bacco use contri	bute to the o	cause of deat	:h?									
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000	law re nas be e 2 sh	Completed	Chronic	OW (NO	CIIV	er	Muona	vig 1.	24a. Was a autops	sy p	rior to comp	findings availetion of caus										
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ita	sician certifi irecto	Be o	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Othe	-	Check only one)	M		3										
5	a Physer this eral d	e: To	27. Manner of Death	28a. Date of	injury	ER/Outpatient 28b. Time of	3 L DOA 28c. Injury	4 L Nursir	ng Home 5 Reside													
uc	nding ath. r: Afte re fun	icat	1 Natural 5 Pendin Accident Investig	9	Day, Year)	injury	work?	/es 2 □ No	ĺ	,,												
Division of Vital Records,	Il or Atte after de Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 28e. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number n, State)	r or Rural Ro	ute Number,										
_	e Hospita 124 hours e Funeral letely fille	Medical	(Check 2 Medical E	Physician: To the best xaminer: On the basis of Nurse Practitioner: To	of examination	and/or investi	gation, in my opinior	, death occurr	red at the time, date an	d place, and due	to the cause	(s) and manne	er stated.									
_		<	29b. Signature and title of certifier	11/	M 1/	CIN.	License			29d. Date signed												
	20		7 Many	el V	UP	UIH	TUM		SWI		110	0110										
			Emani	vho completed cause d	death (tem	3a) (Type Pr	TAK	151	^	e Philip ey, MD 2												
	Stat Registra	-	31. Date filed (Month, Day, Year) SEP 2 7	2012 Septe	strar's Signat	· par	Med.															

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\substack{\text{State}\\ \text{Registrar}} \text{AMEND\#2} \\ \text{perMD, } 10/11/12; \\ \text{EMW,MoCo}$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sheila Ronnie EISIG September Medical 3:00 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death <u>Medstar Montgomery Medical Center</u> Montgomery Olney **Funeral** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 New York (Month, Day, Year Nov. 24, 122-30-0610 Davs Hours Year) **Director** 1 🗆 M 2 🙀 F 72 1939 Usual Residence of Decede 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery Silver Spring 1 ☐ Yes 2 🕅 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2511 Holman Avenue 20910 United States Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items urry or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Ş Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. If Yes, Give white 3 Widowed 4 Divorced Completed Specify. Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Colleg2(1-4 or 5+) Accountant Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Leibowitz ၉ Jacob Morris Krakower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William David Eisig, Son 23502 Buckridge Drive, Damascus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once, 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Judean Memorial Gardens 10/03/12 Olney, MD po al Service Lice su Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ OBSTructive JADN disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 as attending detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 140 Day Year Yes the 8 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ car Cancer Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform ☐ Yes 2 🗷 1 Yes 2 No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No 1 Yes မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: To the Hospital or Attending I within 24 hours after death. within 24 hours after death. To the Funeral Director: After 28d. Describe how injury occurred Vatural 5 Pending the Accident Investigation Suicide 6 Could not be pletely filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practitioner: To the best of my knowledge, death 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 10

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who comp

Ata Motamedi,
31. Date filed (Month, Day, Year)

M.D.,

01 2012

17904 Georgia Ave., Suite 304, Olney, MD

20832

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ George Joseph Ellis, Jr. September 3:23p ^M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Montgomery Bethesda Social Security Number If Under 1 Year If Under 24 Hrs 7, Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) June 5, 1933 1 **№** M 2 🗆 F Months Hours Min New York Director 062-26-7964 79 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Falls Church Fairfax Co. VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6369 Waterway Drive 22044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. I Hygiene. other than "natural", Specify 3 X Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Education Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ George J. Ellis Catherine A. Driscoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau 2800 Flagmaker Dr., Falls Church, VA 22042 Burton Ellis (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) National FH & Crematory 9/28/2012 4 Donation 5 Other (Specify) Falls Church, Signature of Funeral Service Murphy Falls Church Funeral Home 22. Name and Address of Facility 1102 W. Broad St., Falls Church. VA 22046 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ OOXI 4-5 weels Medical Due to (or as a corls Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ 1 Live Birth 2 Fetal deat
4 Pregnant at time of death
9 Unknown in the past 12 months? Month Yes 2 No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an cate has page 2 s autopsy performed? prior to completion of cause of death? No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 \(\subseteq \text{Yes} Other: ᇋ 2 XNo Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending Division 2 🗌 No 1 Yes ☐ Accident Investigation 24 hours after deat Funeral Director. 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and/or investigation is much in the cause of examination and or investigation is much in the cause of examination and or investigation and or 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 Indrea 40 12 ne and address of person who completed cause of death (Item 23a) (Type, Print) 10 10 Center Drive, Bethesda, MD 20892

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month ам Marv Elizabeth Elliott 2012 September 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days 89 09/09/1923 216-18-2520 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 🖵 Yes 2 🗌 No Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 Staton Street 21826 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturing Seamstress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Selby Esham Eva Kay Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Keith A. Elliott/Son 34046 Clearfield Dr., Pocomoke City, MD 21851 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pla Wicomico Memorial 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 0/29/2012 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 noson CESP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Te disease or condition resulting in death) Sequentially list conditions, Due to for as a consciou new off cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 2 No

Physician/ Medical **Examiner**

and

guipo

certificate be Box 68760

P.O. |

Division of Vital Records,

burial-

Physician/

Medical

10a. State

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Examiner

Funeral

Director

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28a-f

23a

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permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once.

must be notified at

the Medical Examiner

Director

Funeral

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Completed

Be

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the Maryland

3altimore, Maryland 21215-0036

Examir -transit ing physician a Physician/Medical þ Completed Be မ Certificate:

IF FEMALE:

Medical

within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page To the Hospital or Attending Physician: 10TC

25. Was case referred to medical examinar? 2 No 27. Manner of Death 1 Natural

Accident

Suicide

4 🗌 Homicide

29a. Certifier

(Check

5 Pending Investigation 6 Could not be determined

and title of certifier

28a. Date of injury (Month, Day, Year)

Hospital

work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

injury

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

City or Town, State)

28d. Describe how injury occurred

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number,

9-26-2012

31. Date filed (Month, Day State Registrar

Registrar's Signa

completed cause of death (Item 23a) (Type, Print)

Backe

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	epartment of Health and I Ce <i>rtificate of Death</i>	2012 33226					
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death						
	Physicia Media		Mary Ellen Falusi		September 22, 2012 8:46 a ^M					
	Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death						
	- 14		Suburban Hospital	Bethesda If Under 1 Year If Under 24 Hrs.	Montgomery					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho 214-32-7876 1 □ M 2 ▼ F 82 Yr	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)					
			Usual Residence of Decedent		March 12, 1930 Washington, DC					
	ryland -f sho ied at	ctor	10a. State 10b. County 10c. City, Town of		10d. Inside Cîty Limits 1 □ Yes 2 ⊠ No					
	ne Ma or 28a notif	Director	MD Montgomery C 10e. Street and Number	hevy Chase 10f. Zip Code	10g. Citizen of What Country?					
	with the 23a cast pe	Funeral	8101 Connecticut Avenue, #N303	20815	USA					
	death items ier mi	Fun		13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- 14. Race - American Indian,					
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No	1 ☐ Yes 2 🛣 No Specify:	Specify: White					
21215-0036	hours natura ical E	lete	15. Decedent's Education 16a. D	ecedent's Usual Occupation	16b. Kind of Business/Industry					
212	iin 72 ie. han "r	dwo	Elementary/Secondary (0-12) College (1-4 or 5+)	Rive kind of work done during most of work e. DO NOT use retired)	Naval Surface Warfare					
7	d with tygien ther ti nt, the	Be C	17. Father's Name (First, Middle, Last)	thematician	Center ne (First, Middle, Maiden Surname)					
Maryland	be filed ental Hy ked oth ic event	2	Joseph A. Falusi		Illen Finn					
ary	should and Me is marl raumati				ral Route Number, City or Town, State, Zip Code)					
	and 2 s Health s em 27 i				00, Washington, DC 20006					
altimore,			20a. Method of Disposition 20b. Place of Disposition 1 🖺 Burial 2 🗆 Cremation 3 🗀 Removal from State	pisposition (Name of crematory or other place) f Heaven	Date t. 25,					
<u>=</u>	iit. Page urtment c ortant: If njury or			emetery	2012 Silver Spring, MD					
Ba	permit. Departr Imports any inju	0	N. V. 1. 100 00 1100	Francis J. Collins	Funeral Home Inc W., Silver Spring, MD 20901					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.							
-	Physician/		Immediate Cause (Final disease or condition Intracranial Hem	orrhage non-t	ogset and Death					
1	Medical Examiner		resulting in death) Due to (or as a consequence of)							
		ē	Sequentially list conditions, b. Due to (or as a consequence of)	P	magme					
	ansit and	amir	cause. Enter Underlying Cause (Disease or injury that initiated events C.	sea har						
	ate be executed hysician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of)	(Va 8) 4	3 9/34/12					
09/	te he	gici	d	Ch.	1 1 1					
687	certifica nding pl use as t	ian/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery					
30X	e atter	sicia	in the past 12 months? 1 Yes 2 No 1 Helterum	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year					
O.	t the c	E S	9 Unknown Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I	23e. Did tobacco use contribute to the cause of death?					
σ.	requires that the tree signed by should be detected	슬	Part II. Other significant continuous continuous to death out not resulting in	and disastrying dadoo grown in tari	1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown					
ğ	requir Leen should	lete			24a. Was an 24b. Were autopsy findings available					
Division of Vital Records, P.O. Box	Physician: The law this certificate has al director, pege 2	Completed			autopsy performed? prior to completion of cause of death? 1 □ Yes 2 ☒ No 1 □ Yes 2 □ No					
a F	ian: T	BeC	25. Was case referred to medical examiner?	26. Place of Death (Chec						
\leq	hysic this ce al dire	i P	1 Yes 2 □ No		ome 5 Residence 6 Other (Specify)					
n 0	After funer	äte	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) injury inj		28d. Describe how injury occurred					
isio	or Attend after death Director: / I in by the	Certificate:	3 Suicide 6 Could not be		28f. Location (Street and Number or Rural Route Number,					
. <u>≥</u>	tal or its after all Direction led in	S S	building, etc. (Specify)	building, etc. (Specify) City or Town, State)						
	To the Hospital within 24 hours To the Funeral I completely filled	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or	nvestigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s) and manner stated.					
	o the o the comple	Z	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge. 29b. Signature of the best of certifier.	29c. License number	lace, and due to the cause(s) and manner as stated. 29d. Date \$\int_{\text{gligned}}^{\text{gligned}}(Month, Day, Year)					
	5	Ŕ	▶ #	20061302	9/22/12.					
	IA IA		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	1- MD 2001/4					
	-0-			setown Road, Bethese	aa, rw 20814 (
	Sta Registr		31. Date file (Month, Day, Year) SEP 2 5 2012 33 Registrar's Signature	barke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		TOI.	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2012 33227
		Registrar 1. Decedent's Name (First, Middle, Last)	
Physicia		Katerina Finokiaro	2. Date of Death Month Day Year September 26, 2012 2:35 p M
Medio Examir		4a. Facility Name (if not institution, give street and number)	September 26, 2012 2:35 p M 4b. City, Town, or Location of Death 4c. County of Death
		Sacred Heart Home	Hyattsville P.G.
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month, Qay, Year) Country)
Director		577-54-4060	Months Days Hours Min. (Month, Day Year) April 30, 1912 Siovenia
and Show	'n	10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limits
Maryla 28a-f	rect	MD P.G. Hyat	tsville 1 □ Yes 2 🖰 No
a or 2	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
th witl ns 23 must	ner	3805 Oliver Street	20782 Italy
r deal	by Fu	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \[\text{Never Married 2 } \] Married 1 \[\text{Yes 2} \] No	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
urs afte urral", o		3 Midowed 4 Divorced Sear or Dates.	1 ☐ Yes 2基 No Specify: White
"natu	Completed		dent's Usual Occupation kind of work done during most of working
hin 7%	E O	Elementary/Seconday (0-12) College (1-4 or 5+) life. I	DO NOT use retired)
ed wit Hygie other	Bec	8 H	Own Home 18. Mother's Name (First, Middle, Maiden Surname)
be file ental ked o	户	Antonio Kovac	Maria Kusterle
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 s Health tem 27			5 Oliver Street, Hyattsville, MD 20782
Page 1 ament of Hant; if ite		20a. Method of Disposition 1	matory or other place)
Deficiency Department of mportant; If it any injury or o		4 Donation 5 Other (Specify)	matory or other place) Heaven 2012 Silver Spring, MD emetery
permit. Departinimporta		21. Signature of Superal Service Licensee	2. Name and Address of Facility rancis J. Collins Funeral Home Inc. DO University Blvd. W., Silver Spring, MD 20901
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying, such as cardiac or respiratory arrest, Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Dementia	Interval Between Onset and Death
Medical Examiner		disease or condition resulting in death) a. Dementia Due to (or as a consequence of):	
Examine	į.	Sequentially list conditions, b.	
o sit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (ursease or mijury	
xecut	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):	
ate be executed whysician and the burial-transit	dical	d	
ertificate ding physe as th	Med	IF FEMALE:	
th cer ttendii	sician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (energy) Month Day Year
e dear the all	ysic	1 ☐ Yes 2 ☒ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify) Month Day Year
hat the	y Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
uires t n sign	ed by	Chronic Kidney Disease, Hypertension	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown
law requires has been signed 2 should b	plet		24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
The la ate ha	Completed		performed? death? 1 \(\sum \text{Yes} \ 2 \) \(\sum \text{NN} \) 1 \(\sum \text{Yes} \ 2 \) \(\sum \text{NN} \) 1 \(\sum \text{Yes} \ 2 \)
cian: certific setor,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one)
Physi this o	은	1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time	
ding P th. After til	cate	1 X Natural 5 ☐ Pending (Month, Day, Year) injury	of 28c. Injury at 28d. Describe how injury occurred work? M 1 □ Yes 2 □ No
Atter Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	
ital or its after al Dir	S	building, etc. (Specify)	City or Town, State)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, and due to the cause(s) and manner as stated. stigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
o the vithin of the omple	ž	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year)
		Mowdy	
		30. Name and address of person who competed cause of death (Item 23a) (Type,	
		Nurul Chowdhury, 🖽 605 Main Str	eet, Laurel, MD 20707
Sta Registr		31. Date filed (Month, Day, Year) OCT 01 2012	Med.
riogiali	-	The same with the same of the	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 26, 2012 11:00 A M Mary Ethel Farrell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's St, Mary's Nursing Center Leonardtown 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 94 212-30-7733 Director 1 □ M 2 🖾 F June 21, 1918 MD Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Charles Newburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20664 10015 Venus Rd. 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Federal Government Payroll Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margurite Gibbons Zachary Mattingly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is 1 any injury or other traumonce. 41720 Knight Rd. Leonardtown, MD 20650 Rose E. Moe/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ghost Church Cem. 9/29/2012 Issue, MD Signatura Funeral Service 22. Name and Address of Facility Arehart-Echols Funeral Home, PA MO0945 P.O. Box 567 LaPlata, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final 2 heime Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Dav Pregnant at time of death g Unknown 9 Unknown signed by to Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performe 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funer 1 Natural work?
1 Yes 5 Pending M 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 068923

80-10

State

Vijaya Guduri,

30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

Hollywood, MD 20636

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33229 Reg. No. 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 230, 2012 9:15P. ВЕЛЛАН Е. FREEMAN Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Prince George's 4b. City, Town, or Location of Death **Examiner** 4818 Olympia Avenue Beltsville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Aug. 15, 1925 Virginia 230-20-1644 87 Yrs Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director Beltsville 1 Tyes 2 No Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20705 United States 4818 Olympia Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐XNo If Yes, Give þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Safeway stores Meat Wrapper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Flossie Morris ဂ္ John Collier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 4818 Olympia Avenue Beltsville, Maryland 20705 Joan Morris -daughter in law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Holly Memorial Gardens 10/5/2012 Charlottesville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Bonald Avess Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complicat of sithat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one of use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last physician are s the burial-t Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ٥ 1 Yes 2 No 3 Probably 4 Unknown Completed quemonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No Acidosis 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 😾 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 Records, Division of Vital n 24 hours atter uccu... he Funeral Director: After th noleted filled in by the funeral

31. Date filed (Month, Day, Year) State 1 6 2012 Registrar

29a. Certifier

Medical

and address of Jerson who completed cause of death (Item 23a) (Type, Print)

Gertifying Nurse Frantioner: To the best of my knowledge, death on

KathyAnn Walcott, M.D. KP 12201 Plum Orchard Drive Silver Spring, MD 20904

32. Registrar's Signatur

**Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D54099

diat the time, date and place, and due to the

29d. Date signed (Month, Day, Year)

October 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Ma	aryland	•	artment of F <i>tificate of E</i>		-		012	33230
	Physicia	n/	Decedent's Name (First, Middle, Las	t)					2. Date of De Month	The same of	Year	3. Time of Death
	Medic	al	Lauren 4a. Facility Name (if not institution, give	Jayne street and number		Gunn		Location of Death	500	22 2	v of Deathy	0854 M
	Examin	er	1 1	wood F	2d		ROC	CUI/	8	00	y of Deathy	Somery
	Funeral Director		5. Social Security Number 6. Social Security Number 139-48-9563	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov • 3	th , 1951	9. Birth Count	lace (State or Foreigh
	nd thow at	or	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation				10	0d. Inside City Limits
	Maryla 28a-f s otified	irect	MD Montgo	nery	Roc	kvill	e					1 ✓ Yes 2 □ No
	with the 23a or ust be n	Funeral Director	10e. Street and Number 1112 Highwood	Road			10f. Zip Code 20	851		10g. Citizen of	What Coun	try?
036	e fied within 72 hours after death with the Maryland tal Hygiene. At other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates.		· ·	Vas Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto		Bla	ce - America ck, White, e /: Whit	tc.
215-0036	72 hour	Completed	15. Decedent's E (Specify only highest gra	ducation	- 1	(Give I	lent's Usual Occup		ing	16b. Kind of E	Business Ind	lustry
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Maryland 21	be filed ental Hy ked oth c event	To Be	17. Father's Name (First, Middle, Last) Thorndyke Lew	is Roe				18. Mother's Nam				
lary	1 and 2 should be file of Health and Mental I item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	g Address (Street a					
ნ. (გ	and 2 Health em 2: ther t		Richard L.Roe/	Brother	20b. Pl		9 Monto		rive S	20c. Location		
Baltimore,			1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		ce	emetery, cren	eake Cre	e) !		Belts	•	
Balt	permit. Page Department of Important: If any injury or once.		21. Signatur of Funeral Service Vicens		÷/. 11=					RAL SEF	RVICE	,P.A ,Md20910
	hysician Medical	20	23a. Part 1. Enter the disease, or composition shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		SE	VI	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b. Due to for as a	concediu	anco of					_	
	on Diagram	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events C.									
.	certificate be executed anding physician and use as the buriates	edical E	resulting in death) Last	Due to (or as a	conseque	ence of):						
09/89	tificate ing phy e as the	Medi	IF FEMALE:	u								
Š n	death ne atte ed for	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 1 decired at 1 ☐ Pregnant at 1 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnanc Other (specify)	ey			ate of delive onth	ry Day Year
ds, P.O	The law requires that the ate has been signed by the page 2 should be detach	by	Part II. Other significant conditions of	ontributing to death be	ut not resu	ulting in the u	nderlying cause giv	ven in Part I.		obacco use con Yes 2 🗆 No		e cause of death?
Vital Records,	: The law re cate has be ; page 2 sh	Completed	Alexander and a						24a. Was auto perfo 1 \(\sum \) Yes	psy prmed?		sy findings available npletion of cause of 2
Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	Hospital:	ent 2 \square F	EB/Outpatier	26. Plant 3 DOA Other	ace of Death (Checer: 4 Nursing He		dence 6 Oth	ner (Specify)	
וס ר	fing Ph .r After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of injur (Month, Day	у :	28b. Time of injury	28c. Injury work	/ at ?		now injury occur		
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific tompleted filled in by the funeral director,	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined					Yes 2 □ No	28f. Location (S City or Tox	Street and Numb vn, State)	per or Rural	Route Number,
ם	Hospita 24 hours Funeral sted fillec	Medical	Check 2 Medical Exami	ician: To the best of r ner: On the basis of ex	amination	and/or invest	igation, in my opinio	on, death occurred a	t the time, date a	and place, and du	ue to the cau	se(s) and manner stated.
	To the vithin To the	Σ	only one) 3 Certifying Nurs 29b. Signature and title of certifie	se Practioner: To the t	oest of my	knowledge, o	29c. License		ce, and due to th	29d. Date signe		
	6		Jun 20 (2)	secker	m	Om	- 10 -	10428	5	Dep	24	2017
			30. Name and address of person who c	ompleted cause of de	eath (Item	,	Print) OME	524 HO	SPA	Lach	no	20904
	Sta Registra	le ar	31. Date filed (Month, Day, Year) SEP 2 6 201	2 32 Registra	r's Signati	· pa	Mad		1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 844 LINDA S. GILDAY 20/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center BALITMORE University of Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Min. Hours 218-56-8100 Director 1 M 2 V F 62 Sept. 14, 1950 Washington, DC Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits the Maryland at Director or 28a-f sle notified 1 Yes 2 X No MD Montgomery Silver Spring 10e. Street and Number 10a. Citizen of What Country? "natural", or items 23a o Funeral within 72 hours after death with 11009 Amherst Avenue 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc 1 K Never Married 2 Married 1 Yes If Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X☐ No Specify: 3 Widowed 4 Divorced Year or Dates er than "natur the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Office of Information Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Technology- Univ. of MD it. Page 1 and 2 should be filed with rtment of Health and Mental Hygier rtant: If item 27 is marked other t njury or other traumatic event, th <u>Coordinator</u> is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mark Edward Gilday Bonnie Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 27 Department of Health a Important: If item 27 Bonnie Ward Gilday/Mother 11009 Amherst Avenue, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Sept 29, 1 Burial 2 Cremation 3 Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. CM9A p00 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SEPSIS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) P The law requires that the death certificate be executed Cause (Disease or injury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last buria Physician/Medical Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No be detached 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by morbid 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, nours after death.

neral Director; After this

filled in by the funeral d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at Hospital or Attending 1 Natural Accident 5 Pending iniury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 26 12 7 497066583

DHMH 17 Rev 06-2011

State Registrar University of Maryland Ward Cutter, Battimore, un.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

Giuliana Ereng-Ramosimo

12-07608 Nonzo Glascoe		Please Type or Print in Blac					gible.		
NOTIZO GIASCOE		State of Maryland / I			nd Mental I	Hygiene		2012	3323
Dh. c'.		Registrar	Certific	ate of Death			g. No.	2012	. 3323
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) Alonzo E.		C1		Date of Deat Month	Day	Year 3	. Time of Death
'W.		Alonzo E. 4a. Facility Name (if not institution, give street and number)		Glasco		October 7	, 2012		1725 hrs
j		Johns Hopkins Bayview Medical Center		Baltimore	or Location of Dea	ath	4c. C	ounty of Death	
Funeral			n yrs. last bir		KII 041	lo pote strict			
Director					ear If Under 24H ays Hours M	in.		/YYYY) 9. Birthp Foreign	
			50	Yrs.		May 2	,195	2 Was	MingtonD(
any		Usual Residence of Decedent 10a. State 10b. County 10	c. City, Town	ost certice					
.		1.00	-						0d. Inside City Limits
Maryland 28a-f show	호	Maryland Anne Arundel 10e. Street and Number	Anna	polis					X Yes 2 No
5 72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.	Director			10f. Zip Code		10	g. Citizen	of What Country	/?
th the 23a o		505 Post Oak Rd	_	2140			US	A	
th wi	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	er in U.S.	13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Specify Yes or No-	14.	Race - America	n Indian, 8lack,
r dea	Ξ	1 Yes 2	No			to recar, etc.)	i	Wille, etc.	
s afte	ğ	3 Widowed 4 X Divorced If Yes, Give Year or Dates:		1 Yes 2X N			Spe	ecify: Blac	k
hour natu	be	15. Decedent's Education (Specify only highest grade comple	ted) 16a.	Decedent's Usual Occup during most of working life	ation (Give kind of fe. DO NOT use re	f work done	16b. Kind	of Business/Ind	ustry
0036 within 72 iene. er than '	pe	Elementary/Secondary (0-12) College (1-4 or 5+)				,			
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	1 2 17. Father's Name (First, Middle, Last)	!	Elevator					n House
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21215-0036 ould be filed within 7 Mental Hygiene. I marked other than		John G] 19a. Informant's Name/Relationship (Type, Print)	asco	h Mailing Address (O)	Carri	<u>le</u>		Jeni	
MD 21215-0036 to 2 should be filed within the and Mental Hygiene. a 27 is marked other than unmatic event, the Medic	_			b. Mailing Address (Stre					
구 등 등 등		Patrick Glascoe/ Son 20a. Method of Disposition	20b Place	1904 Dover	emetery	Date		MD ZII. ation - City or To	
Ore ges 1 rof H	Н	1 Burial 2 Cremation 3 Removal from State	cremat	ory or other place)	-			•	
t. Pa		4 Donation 5 Other Specify:	Que	en of Peac		-13–12	Mech	anicsv	ille MD
Baltimore, permit. Pages 1 at Department of He. Important: If ite		21. Signatur II Funeral Service Licensee		22. Name and Addres				- 100	
Physician		23a. Part I. Enter the disease, or complications that gaused the	doeth De se	Adams Fu	neral F	lome Pa	, Aq	uasco l	
/Medical		failure. List only one cause on each line.					st, shock,		Approximate Interval Between Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)		Remote Guns	hot Wour	ıd			Death
="		b but to (or as a conseque	ence of):						
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ed	Examiner	events resulting in death) Last	ence of);						
executed an and al - transi	cal	UNPENDED AMENDED 23a, 2	7.28a-	f,per me,g9	34 12-4-	.12 cm			
	e G				J7 12 7	12 311			
876 ificat	퇼	IF FEMALE: 23b. Was decedent pregnant in the	f pregnancy	Fetal death 3	Estaria assur			ate of delivery	
Box 68760, i death certificate be the attending physicical for use as the burned for use	S.	past 12 months?	of death 5		Ectopic pregr	iaricy	Mor	nth Day	Year
BO deat	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown		Cirler (Opcomy)					
P.O. ss that the gned by e detache		Part II. Other significant conditions contributing to death bu	t not resulting	in the underlying cause	given in Part I.	23e. Did tob	acco use	contribute to the	cause of death?
, P.C ires that signed I be deta	d by					1 Yes	2 🗸 No	3 Probabl	y 4 Unknown
rds requi	쁄					24a. Was ar	n 2	24b. Were autop:	sy findings available
e law e has	Completed					autops: perform		prior to comp death?	oletion of cause of
tal Re	ပ္ပု	25. Was case referred to medical				1 ✓ Yes 2	No	1 Yes	2 No
of Vital Records, ig Physician: The law require ther this certificate has been si neral director, page 2 should be	Be	examiner? Hospital:	2 52/0		of Death (Check				
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nding th.	Certification:	1 Natural 5 Reading (Month, Day,Year)			Yes 2 X No	subject			
Division ral or Attendi rs after death. al Director: /	ۊ	2 Accident Investigation 10 1980		nown 1 mm, street, factory, office					
Divisospital or A hours after meral Dire	튑	determined (Cassifu) unk	nown	im, street, factory, office	building, etc.	or Town, Sta	reet and N ^{ate)} un k	lumber or Rural I	Route Number, City
lospit hour		4 A Homicide				1			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil	Medical	consider the control of the best of my knoone) Certifying Physician: To the best of my knoone) Wedlcal Examiner: On the basis of examina	owledge, dea ition and/or ir	ith occurred at the time, divestigation, in my opinion	late and place, and n. death occurred	d due to the causer	(s) and ma	anner as stated.	use(s)
To To	9	and manner stated. 29b. Signature and title of certifier		29c. Licens					
	-	0 11		O.C.				signed (Month,	∪ay, rear)
		JWI. CL			IVI.E.		Octobe	r 8, 2012	
		30. Name and address of person who completed cause of death Jack Titus MD. Deputy Chief Medical Exan		0 \\/ Baltimass Cts	not Politica	MD 04000			
	ate	31. Date filed (Month, Day, Year) 32. Registrar's S		o vv. bailimore Str	eet, Baitimore	, IVID 21223			
St. Regist	_	OCT 1 1 2012	igi iature	hadl					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 10:34 AM 20 2012 6000 Medical 4a. Facility Name (if not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manyland Medical Center of altimore Security Number 8. Date of Birth (Month, Day, Year) 1936 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Sierra Leone, 220-31-6334 **Director** 1 🗆 M 2 🗶 F 76 February 26, West Africa Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f 1 X Yes 2 No Maryland Germantown Montgomery ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 20876 United States 11843 Regent Park Drive 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Race - American Indian. Black, White, etc. 9 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", 3 X Widowed 4 Divorced Specify: **Black** Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Sierra Leone Civil and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Service Commission years Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Koomber Onike 0 4 1 Joannis Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 11843 Regent Park Drive; Germantown, Maryland 20876 Festina Manly-Spain (Daughter) injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Page 1 Oct.14,2012 Freetown, Sierra Leone, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ascension Town Cemetery West Africa permit. 22. Name and Address of Facility R.N. Horton Company Morticians, annature of Fineral Se M01421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph. sician/ struke disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Luis to (or as a nonsequence of): If any, leading to immediate cause. Enter Underlying requires that the death certificate be executed burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Month Day Year signed by the at Id be detached fo Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 has autopsy death? certificate | 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ျင 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S G reene St, Baltimore, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State "saute Registrar

Timothy Grady

12-07285 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Timothy Michael Grady, Sr. Medical Examiner 1206 hrs September 26, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7714 Hanover Parkway Greenbelt Prince George's 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** 214-52-5558 Days Months Hours Director 1 ▼ M 2 F 63 April 21, 1949 Washington, DC Usual Residence of Decedent III A 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show r 1 Yes 2 No Maryland Prince George's Greenbelt Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.

tant: If item 27 is marked other than "natural", ar items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7714 Hanover Parkway, #202 20770 United States Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? White, etc. 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Mental Hygiene. marked other than "cevent, the Medical Elementary/Secondary (0-12) College (1-4 or 5+) D 21215-0036 12 Serviceman Washington Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William John Grady, Sr. Mary Scalan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route number, City or Town, State, Zip Code) 7714 Hanover Parkway, #202 Greenbelt, Maryland 20770 Diane L. Grady -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Tc.yn. State crematory or other place) Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 10/2/2012 Alexandria, Virginia 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses Bornald Vies Borg Wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 on 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode or dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva **Physician** Between Onset and /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease **E**gaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital ar Attending Physician: The law requires that the death certificate be executed Physician/Medical x AMENDED 23a, pt. II, 27, per me, g932 #1 as noted, per me, g933 11-20-10-23-12 smX UNPENDED attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 V Unknown Diabetes Mellitus, Chronic obstructive pulmonary Completed 24a. Was an 24b. Were autopsy findings available disease, chronic alcohol abuse prior to completion of cause of autopsy certificate has death? performed ✔ Yes 2 No 1 🗸 Yes 25 Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) After 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 X Natural 1 Yes 2 No Pending in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 24 hours a 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME September 27, 2012 w 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

31. Date filed (Month, Pax Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hartnett Joseph Lawrence October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Maugansville <u>14023 Maugansville Road</u> If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 074-12-0686 93 Months **Director** 1 M 2 🗆 F Yrs June 12, 1919 New York Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No MD Washington Maugansville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21767 14023 Maugansville Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian Armed Forces Ayes 2 [f Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 2 🗆 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Automotive <u>Material Handler</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ellen Hartnett ည Jerome Plumadore 19a. Informant's Name/Relationship (Type, Print)
Rita Jane Hartnett / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 14023 Maugansville Rd., Maugansville, MD 21767 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Smithsburg Crematory 10/5/2012 Smithsburg, Maryland 4 Donation 5 Other (Specify) Funeral Se Co 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and De Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or an a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Records, P.O. Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 L 9 ☐ Unknown q | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy performe ours after death.

eral Director: After this certificate filled in by the funeral director, pag Yes 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 10 No Hospital Other: 1 Tyes ုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Natural Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in tity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certific 29c. License number

IW4+1

State

Steven L.

Registrar

13424 Pennsylvania Ave., Suite 203, Hagerstown, MD 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Hatleberg,

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Morth 9 / 21 1/2 01 2 Year 7:20 p_M Gladys Hilton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Silver Spring Holy Cross Hospital 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 03/28/1962 50 Director Dom. Republic 1 □ M 2 1 F 213-13-3061 Yrs Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director DC Washington, DC 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Dominican Republic Funeral 20011 5940 14th St. NW #A3 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. and 2 should be filad within 72 hours effar c Heelth end Mentel Hygiene. tem 27 is marked other than "natural", or other traumatic event, the Medical Examin 1 Never Married 2 Married \$ Specify: Black If Yes, Give 1⊠Yes 2□No Specify:Dominican 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) home interior self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Paola Peguero ည Augusto Perez 19a. Informant's Name/Relationship (Type, Print)
Michelle Hilton-daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5940 14th St., NW Washington, DC 20011 permit. Paga 1 and 2 Department of Heelth Important: If Item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington 9/30/2012 Adelphi, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral 3447 14th St., NW Washington, DC wanda c. Bacon CC0361 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End Stage Breast Cancer with metastasis Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off: burlatteneit Exami Sepsis secondary to above that initiated events resulting in death) Last Due to (or as a consequence of) anding physicien are use as the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month Day Year ad by the a To the Hospital or Attanding Physician: The law requires thet the within 24 hours after death.

To the Funeral Director: After this certificate hes been signad by a completely filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No Yes 2 XN 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 🔀 No 1 🖾 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident 1 Tes 2 🗌 No Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ceptifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Anisha Kumar, MD 1500 Forest Glen Rd. Silver Spring, MD 20910

D73240

09/24/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9/15/2012 Physician/ 2059 BILLY JOE HILL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgamery Shady Grove Adventist Hospital Rockville If Under 1 Year I If Under 24 Hrs. Social Security Number Funeral 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Director 235-70--5565 1 X M 2 □ F 12/9/1944 VA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland important: If item 27 is marked other than "natural", or items 23a or 28e-f sho any Injury or other traumetic event, <u>the Medical Examiner must be notified at</u> Director 1 Yes 2 X No Rockville MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20850 222A Fredercik Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Industry Meat Cutter 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Tommie Lee Alonzo Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 222A FredrickAvenue, Rockville, MD 20850 Belva Jean Hill/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Heaven 9/29/2012 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Usansee 22. Narrie and Address of Facility Snowden Funeral Home 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cardiac tailure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner acute myocardial inforction hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): tate has been signed by the attending physician and page 2 should be detached for use as the buriat transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No ္မ 1 Inpatient 2 TER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 Pending Work: 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

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Maryland 21215-0036 Baltimore, Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funerel Director: After this certific Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifig 9/15/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 990/ Medical Center Dive, Rodevill+, montal 20850 jinder Mudahar, MD 31. Date filed (Month, Day, Year) 37. Registrar's Signature State acks SEP 2 5 2012 Registrar DHMH 17 Rev 06-2011 **ORIGINAL**

12-07402 Wayne Herbert Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2012 33238

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Physicia edical Exami	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month [September		3. Time of Death 1141 hrs
		4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital	4b. City, Town, or Location of Deal Takoma Park		4c. County of Death	
Funeral Director		5. Social Security Number 212-66-6586 6. Sex 17. Age (In yrs. last birthday) 1 M 2 F 56 Yrs	If Under 1 Year If Under 24Hi Months Days Hours Mi		(MM/DD/YYYY) 9. Bird 956 Foreig Cou	hplace (State or Nashington ^{Intry)} DC
i iow any c.		Usual Residence of Decedent 10a. State 10b. County MD Prince George's College Pa				10d. Inside City Limits 1 X Yes 2 No
he Maryland or 28a-f show	Director	10e. Street and Number 9014 Rhode Island Ave.	10f. Zip Code 20740	109	. Citizen of What Cour	itry?
Baltimore, MD 21215-0036 pemit. Pages I and 2 stould be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", nr items 23a or 28a-f show injury nr nther traumatic event, the Medical Examiner must be notified at once.	Funeral		as Decedent of Hispanic Origin? (§ es, specify Cuban, Mexican, Puert		14. Race - Americ White, etc.	
hours after	<u>۾</u>	15. Decedent's Education (Specify only highest grade completed) 16a. Deceden during m	Yes 2 X No specify: It's Usual Occupation (Give kind of ost of working life. DO NOT use re		Specify: Whi:	
21215-0036 suld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9 Tri 17. Father's Name (First, Middle, Last)	uck Driver	ne (First, Middle, Ma	Construe	ction
21215 ald be file Mental H marked o	To Be	Samuel Bernard Herbert Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Mary G Address (Street and Number or	Rural Route Number	(Unk)	Zin Code
MD 2 shot all the and 1 is a 27 is a aumatic	-	Debra Herbert - wife 5016	Niagara Rd., Co	llege Par	rk, MD 207	40
Baltimore, permit. Pages I an pepartment of Hea Important: If iteliniury or other trinings.		1 X Burial 2 Cremation 3 Removal from State Ft. Lincol	In Cemetery 10/	05/2012	Brentwood	
Balt permit Depart Impor injury			lame and Address of Facility Ibadeau Mortuary Park Ave., Gaith	iersburg.	MD 208//	
Physician Medical Examiner		Description of the Computation of the Computat	ne moda of dying, such as cardiac	or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and Death
f		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.				
- Po-	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				:
760, cate be execute physician and the burial - tran	Medical E	d. MENDED 23a, 27, 28a-f, pe	er me,g932 10-19)-12 sm		15
Division of Vital Records, P.O. Box 68760, vithin 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - rans	Physician/Med	past 12 months?	tal death 3 Ectopic pregn	ancy	23d. Date of delivery Month D	ay Year
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Division of Vital Records, P.O tal or strenging Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be dear	Completed			24a. Was an autopsy performs	prior to co	opsy findings available ompletion of cause of
Vital hysicians this certi	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient	26.Place of Death (Check 3 DOA Other Mursi	only one) ng Home 5 Re	sidence 6 Other:	
ion of trending Pheath. tur: After the funeral		27. Manner of Death 1 Natural 2 Naccident 1 Pending 1 Netural 2 Naccident 1 Netural 2 Naccident 1 Natural 2 Naccident 1 Natural 2 Naccident 3 Naccident 4 Naccident 4 Naccident 5 Naccident 5 Naccident 6 Naccident 6 Naccident 7 Naccident 8	1 Voc. 2 Fee No.	28d. Describe how	vinjury occurred ingested d	rugs
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1	Certification	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, stree (Specify) Fd:Residence		28f. Location (Street or Town, State #603 Col1	et and Number or Rur e)9014 Rhode ege Park,	al Route Number, City Island Ave
To the Hospital within 24 hours a To the Funeral 1 completely filled	Medical	29a, Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and/or investigat and manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number O.C.M.E.		9d. Date signed <i>(Mon</i> October 1, 2012	th, Day, Year)
		Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimor	e Street, Baltimore, MD 2	1223		
Sta Regist	_	31. Date filed (Month, Day, Year) 22. Registrar's Signature	1.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death September 26, 201 Physician/ 1-14 land 1:14 PM dward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** . County of Death Prince Regional Hospital George's Laure -durel 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours 045-18-4971 87 Director 1 X M 2 □ F Yrs July 21, 1925 Connecticut permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f -- any injury or other traumatic event, the Marked of the profession of the profes 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏻 No MD P.G. Silver Spring 10f. Zip Code 10g. Citizen of What Country? Funeral 3144 Gracefield Road, Gardenview 426 20904 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Race - American Indian Armed Forces?
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✓ Yes 2

No Black, White, etc. 9 1 Never Married 2 Married If Yes, Give WWII 1 Yes 2 No Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6 Attorney Corporate Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ David James Hyland Charlotte Veronica Griffin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $^{
m MD}$ 2090419a. Informant's Name/Relationship (Type, Print) Melissa Hyland/Wife 3144 Gracefield Road, Gardenview 426, Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 Silver Spring, MD 21. Signature of Fungral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph sician +2 Cu iratory disease or condition Medical resulting in death) Examiner ONORS Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying the buria transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buria transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Liperandon 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 X No 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

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Laurel Regional Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Tourky

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Physician/ SEPTEMBER^{Da}28, JAMES ROBERT HILL 2012 3:25 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES RESIDENCE. 5248 DAVENTRY TERRACE FORESTVILLE If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours (Month, Day, Year) **Director** 219-56-0032 1 【**X**M 2 □ F 60 FEBRUARY 6,1952 WASHINGTON, D.C. 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MARYLAND 1 XYes 2 No PRINCE GEORGES FORESTVILLE 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5248 DAVENTRY TERRACE 20747 UNITED STATES 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces 2 Black, White, etc. ŏ 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify "natural" 3 Widowed 4 Divorced Specify: BLACK traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10TH GRADE HOME IMPROVEMENT CONTRACTOR HOME IMPROVEMENT is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MARY LUVENIA HOLTON JUPITER WILBERT LAWSON HILL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Health PATRICIA A. WARREN-HILL / WIFE 5248 DAVENTRY TERRACE, FORESTVILLE, MARYLAND 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GARDENS 10/6/2012 WALDORF, MARYLAND LYDIA C. THORNTON JOHNSON MO0583 22. Name and Address of Facility THORNTON FUNERAL HOME, 3439 LIVINGSTON ROAD, P.A. INDIAN HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ -IVer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) physiciar Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Month Yes 2 No be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? Yes 2X No 1 Tes ours after death.

eral Director; After this certific, filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕱 No Hospital ၉ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b: Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pendina 1 Tes Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Pa-4

Registrar

DHMH 17 Rev 06-2011

Signature and title of cert

NICHOLAS DEMONACO,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 64234

M.D. 8926 WOODYARD ROAD, SUITE #101, CLINTON, MARYLAND 20735

29d. Date signed (Month. Day, Year)

OCTOBER 1, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mildred Viola Haenftling September 25, 2012 1:25 PMMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Carroll Westminster 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Hours **Director** 218-12-5750 1 🗆 M 2 🔀 F 91 June 22, 1921 New York Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director MD Garrett 1 X Yes 2 No Accident 23a or 2 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Examiner must 215 S. Main St. 21520 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 27 is marked other than "natural", or i traumatic event, the Medical Examin þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Insurance Agent Insurance Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Rev. Carl F. Dauphin Jessie M. Yungblut 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Ann Wildesen/Daughter 27 3457 Uniontown Rd., Westminster, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) yre of Faneral Service Licensee Sept. 29, 2012 Accident, MD Zion Cemetery Signa 22. Name and Address of Facility Newman Funeral Homes, P.A. P.O. Box 275, Grantsville, MD 23a. Part 1. The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE Jse i 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 to 9 Unknown Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 🗌 Yes No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes of Vital or Attending Physician: Was case referred to Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending s after death. Division 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in City or Town, State) within 24 hours a To the Funeral Completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23,2012 Physician/ Medical LENNIS HAMMOND September 1354 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE FT. WASHINGTON HOSPITAL CENTER GEORGE'S FT. WASHINGTON Birthplace (State or Foreign Country)
 NC . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 577-48-8303 1 M 2 F Months Days Hours Min 82 6 Monto Day of 370 Director NC Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location by Funeral Director 10d. Inside City Limits notified MD FORT WASHINGTON 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe 8001 HOLIDAY AVE 20744 US 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No the Medical Examiner ō 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔽 No Specify. Specify: BLACK 3 x Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **FARMER** PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILLARD WILLIAMS ELNORA SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 DIANE HAMMOND/DAUGHTER HOLIDAY AVE , FORT WASHINGTON, MD 20744 20a. Method of Disposition Department of H Important: If ite any injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State MARYLAND NATIONAL 10 - 2 - 124 Donation 5 Other (Specify) LAUREL, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licen 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Therescleration disease or condition resulting in death) (ardio vasa Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D45365 Sida JM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) livings for RI #101 fort washington 1170/ M.D

DHMH 17 Rev 7/2009

State

Registrar

SEP 2 8 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 33243 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 26, 2012 Physician/ Denver Carl Edward Hutchinson, Sr. 5:29 A. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Holy Cross Hospital Montgomery Silver Spring Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Director 234-12-2108 1 🔀 M 2 🗆 F 97 07/20/1915 Charleston, W. Va. or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Md. Montgomery Silver Spring 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1131 University Blvd. W. # 707 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give 【44—【45 Year or Dates. 1 ☐ Yes 2 K No Specify Specify: Black 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 12th General Mechanic/Post Office other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental marked William Hutchinson Amelia Black should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health ar Florence J. Hutchinson/Wife 131 Univ. Blvd.W.#707, Silver Spring, Md. 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Importent: if it any injury or o cemetery, crematory or other place)
Varyland Vets. Cem. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/05/12 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licerses Name and Address of Facility Henry S. Washington & Sons Co., Inc. CC0316 Inal 4925 Burroughs Ave., N.E., Washington, D 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiopulmonary Arrest Medical Due to (or as a consequence of): Examiner Hyper Carbic Respiratory Arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physiclan and I for use as the burlal-transit death certificate be executed Recurrent Aspiration Pneumonia that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Acute On Chronic Kidney Failure 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Sertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) D65069 September 26,2012 55M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirak Lemma, M.D. 1500 Forest Glen Road, Silver Spring, Maryland 31. Date filed (Month, Day, Year State OCT 0 1

DHMH 17 Rev 06-2011

Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.0.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month 9 20/2 Manford L. Hudson 1750 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Medin COMICO TENINSULA SALISBUI Social Security Number If Under 24 Hrs. If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) A Date of Birth Birthplace (State or Foreign Country) Days Hours (Month, Day, Year) Director 217-36-1672 1 🕅 M 2 🗆 F 88 4-14-1924 Delaware 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Evandner must be notified at Director 1 ☐ Yes 2 🛣 No 28a-f Sussex Laurel 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 13591 Wootten Road 19956 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?...
1 Yes 2 No Black, White, etc 5 1 Never Married 2 Married ò Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: White "natural" Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Grain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ည þ Charles Hudson Sarah Dingle 1 and 2 should b of Health and Mer Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Jane Hudson 13591 Wootten Road Laurel, De. 19956 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Odd Fellows Cemetery Department of H Important: If Ite any Injury or otl 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 Removal from State 9-27-2012 4 Donation 5 Other (Specify) Laurel, Delaware Signature of Funeral Service Licenses 700 West Street 22. Name and Address of Facility Hannigan, Short, Disharoon F. H

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan,Short,Disharoon F.H. Laurel, De. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition cumorya Medical resulting in death) Due to (or as a consequence of) [/]Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) signed by the at d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? β Records, 1 🗌 Yes 2 10 3 Probably 4 Unknown cate has been sig ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate I Yes 2 DNo 1 Yes 2 No Division of Vital Physician: 25. Was case referred to it edical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera Certificate: 27. Manner (eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Lattural
2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1214000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) arroll St 31. Date filed (Month, Day, Year) 0 1 2012 22. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH g941 7/24/13 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ SEPT. 2.2 Day 2012 **EDWARD** LESTER HOLLAND 10:10 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ATLANTIC GENERAL HOSPITAL WORCESTER BERLIN Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours Min. June 16, 1918 MARYLAND Director 221-10-3221 94 Usual Residence of Decedent 28a-f shov 10b. County 10a State with the Maryland 10c. City, Town or Location be notified at Director WORCESTER MARYLAND BERLIN 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11315 CAMPBELLTOWN ROAD 21811 USA items 2 death v 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?,

1 Yes 2 No
If Yes, Give ō þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours afterment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the **FARMER** AGRICULTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ LESTER W. HOLLAND LIDA E. HOLLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NADINE H. HOLLAND/WIFE 11315 CAMPBELLTOWN ROAD, BERLIN, MARYLAND 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Σ Burial 2 \square Cremation 3 \square Removal from State injury or Department Important: I any injury or once. 5 Other (Specify) **EVERGREEN CEMETERY** 9/26/12 BERLIN, MARYLAND 4 Donation atura of F neral Service Licensee 22. Name and Address of Facility a HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death the 9 Unknown detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 \sum Yes Other: 2 🗹 No 1 Inpatient 2 Z ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors and the funeral directors. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year) dus nul 20038647 09-27-2012 10 /18 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) fAUZ! SALIS BURY 21804 31. Date filed (Month, Day, Year) Registrar's Signature State **SEP 27** Jacks Registrar 201**2**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Debarment of Health and Mental Hygiene 2 0 | 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER HUTCHISON GARY MICHAEL 2012 4:30A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MARY'S ST. MECHANICSVILLE 9899 GUNTHER DRIVE 8. Date of Birth 9. Birthplace (State or Foreign Country) WASH., DC If Under 1 Year If Under 24 Hrs. Sex Y⊓M2□F JOMOTHY Day3Year 1952 Months Days Hours 60 212-66-3170 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 X No MECHANICSVILLE ST. MARY'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. 29899 GUNTHER DRIVE 20659 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 Yes 2X No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) CARPETING CARPET MECHANIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) IRENE WINDSOR FRANCES GENE THOMAS HUTCHISON 19a. Informant's Name/Relationship (Type, Print) COMPANIO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACE DIANE PHILLIPS MECHANICSVILLE, MD 20659 29899 GUNTHER DR 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State OAKTAND CEMETERY WALDORF, MARYLAND 1 K Burial 2 Cremation 3 Removal from State 10/08/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRAYMOND FUNL.SERVICE, P.A. Signature of Funeral Service Licensee enl 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death Year Month Day Pregnant at time of death

Physician/ Medical **Examiner**

that the death certificate be executed

the

by

P.O. Box 68760

Division of Vital Records,

Physician/

Funeral

Director

or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death v

hours after

should be filed within 72 hand Mental Hygiene.
7 is marked other than "n

permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic

other traumatic

Maryland 21215-0036

Baltimore,

Medical Examiner

10a. State

MD

Director

Funeral

9

Completed

Be

၉

Examine attending physician and for use as the burial-tran Physician/Medical s been signed b should be deta þ Completed certificate has blirector, page 2 s Be မ funeral Certificate:

Medical

Accident

29b. Signature and title of certifier

30. Name and address of pe

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

(Check

Investigation

determined

6 Could not be

within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu State

• Hospital or Attending Physis 24 hours after death.
• Funeral Director. After this of

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Jennifer Schmidt 20900 Merchants Ln.STE: 201 Leonardtown, MD, 20650

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

io completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 08^{bay} Month 10 2012 01:25 A M James Edward Hood Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** (Month, Day, Year) Days Hours Director 213-36-9776 1 X M 2 □ F 73 MD 03/28/1939 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Tes 2 No Taneytown Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 21787 1941 Trevanion Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 10 If Yes, Give —10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White -19633 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BAE Systems tank assembler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Gertrude Marie Barber Wilbur Hood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1941 Trevanion Road, Taneytown, MD 21787 Nora K. Hood/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place Carroll Cremation 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 10/09/2012 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Prints Funeral Home and Chapel 21. Signature of Funeral Service Licensee 1.212 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 □ No detached a 🗌 Unknown g 🗌 Unknown signed by till Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director After this certificate has been signompletely filled in by the funeral director, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) IN PATIEN 2 No 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 5 Pending 2 🗌 No 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on 29b. Signatu 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lois G. Hastings Physician/ September 28, 2012 7:20A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Renaissance Gardens at Riderwood Village Silver Spring Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X 92 577-18-4440 JUIV30, 1920 Washington, DC Director Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Prince George's Silver Spring Maryland 1 ☐ Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? items 23a 3160 Gracefield Road,#1527 20904 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc "natural", or 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 XNo Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (012) College (1-4 or 5+) Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) Beaulah Reynolds 17. Father's Name (First, Middle, Last, Elijah G. Gentel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34C Ridge Road Greenbelt, Maryland 20770 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lynwood Hastings -son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Metropolitan Crematory 1 Burial 2 XCremation 3 Removal from State 9/28/2012 |Alexandria, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Warald 4.13 on 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Orset and Death 20 Vears Physician/ Arteriosclerotic Cerebral Vascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Hypertension 25 years Sequentially list conditions cause. Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence or). Exami sician and burial-transit 25 years Hyperlipidemia that initiated events resulting in death) Last Due to (or as a consequence of): anding physician ause as the burial-Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 wonths? for Month Pregnant at time of death Day Year been signed by the should be detached To the Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? b dementia; coronary artery disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has tall director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \sum Yes 2 \sum No Other: 4 XNursing Home 5 A Residence 6 Other (Specify) ျပ 1 Inpatient 2 ER/Outpatient 3 DOA this 24 hours after death.

E Funeral Director: After thi leted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2.

To the F
complet 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address of person with completed cause of death (Item 23a) (Type, Print)
Eileen Gemmell, CRNP 3110 Gracefield Road Silver Spring, Maryland 20904 30. Name and address of per-

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 6 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2 Physician/ Month Henry Alan Houchens DM Medical eptember 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death late onter If Under 24 Hrs. 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) Months Hours Min (Month, Day, Year) 219-64-4557 Director 1 X M 2 🗆 F Yrs 57 09/07/1955 Maryland items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Director Waldorf Charles 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5022 Damselfish 20603 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. or. Black, White, etc. Completed by 1 Never Married 2 Married White If Yes, Give 1 Yes 2 No Specify: "natural", 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Silvers ... and Mental Hygiene.
27 is marked other than "r (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Painter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Henry Hunter Houchens Lydia Ann Lutz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 any injury or other tra 5022 Damselfish Ct., Waldorf, MD 20603 Drema Yeager/Companion 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cemetery 09/29/12 Lakemont Davidsonville, MD 21. Signature of Funeral Service Licensed 22. Name and Address of Facility Raymond Funeral Svc., M01517 5635 Washington Ave., La Plata, MD20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death dragea 250 disease or condition Medical resulting in death) as a corts **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events as the burial-tran resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ for in the past 12 months? Pregnant at time of death Month Day Year detached 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 2 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After 28c. Injury at 28d. Describe how injury occurred **Natural** 5 Pending iniury 1 Yes 2 No the Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier

Registrar

31. Date filed (Month, Day, Year,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09725/2012 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8323 Warfield Road Gaithersburg Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 213-56-4639 (Month, Day, Year) Director 1 X M 2 □ F 62 Yrs. 2/22/1950 WASH, DC ıtal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Gaithersburg MD Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8323 Warfield Road 20882 Montgomery 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give 3 Divorced 4 Divorced Completed Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail and Mental Hygie is marked other 3 vrs Salesman-JcPennev Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Francis E. Johnson, Sr. Anna Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul M. Johnson /brother 7220 Barcellona Drive, Gaithersburg, MD 20879 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it eny Injury or o F Burial 2 ☐ Cremation 3 ☐ Removal from State St. Paul Cemetery 10/2/2012 Poolesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 00 2m Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of: for use as the burial- ransit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day ate has been signed by the a page 2 should be detached f 1 Yes 2 9 Unknown a I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown Carcinoma 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 1 within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 \(\triangle \) Nursing Home 5 \(\triangle \) Residence 6 \(\triangle \) Other (Specify) မှ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practitioner: Xi the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rame 3370 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2012 LaVerne Jones 09 20:28P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7000 Beacon Place Riverdale Prince Georges 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🔀 F Days Months Hours **Director** 579-74-3502 06/24/1953 Washington DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Riverdale TYL Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7000 Beacon Place 20737 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Williams Bank Sr. Lillie Pitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Leroy Jones 7000 Beacon Place Riverdale Maryland 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other 5 Other (Specify) 4 Donation 21. Signature of Pure al Septice Licensee 22. Name and Address of Facility 23a. Part 1. Enter the discrese, or complications that caused the death. Do not enter the mode of dyin a such as cardiac of the caused the death. shock, or heart failure. List only one cause on each line Interval Betweer Onset and Doath Immediate Cause (Final Physician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (ar as a consequence of nding physician use as the burial Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death the 9 Unknown Unknown Records, P.O. s been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy Hospital or Attending Physician: The certificate Yes 2 400 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 LINO မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural 5 Pending iniury 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

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who completed cause of death (Item 23a) (Type,

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PATRICK **JENIFER** September. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charl La 8. Date of Birth (Month, Day, Year)
Jun. 29, 1920 **Funeral** 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days 213-16-2998 Director 1 1 M 2 □ F 92 Yrs. Maryland 28a-f show death with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Charles Hughesville 1 X Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 6560 Place 20637 Masontown USA "natural", or items 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 🛣 No Specify: If Yes Give 3 X Widowed 4 Divorced Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Foreman Government 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Koska Jenifer Susie Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John M. Jenifer 2221 Old Fort Hills Dr., Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State St.Mary's Cath. Ch.Cem 10/08/2012 4 ☐ Donation 5 ☐ Other (Specify) Bryantown, MD 21. Signalure of Function Service License 22. Name and Address of Facility Jordan Funeral Service, Inc. CC0341 4001 Benning Rd., N.E., Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician a Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an or Attending Physician: The law autopsy performed? After this certificate has 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and t 29d. Date signed (Month, Day, Year) 0061652 53n 30. Name and addre use of death (Item 23a) (Type, Print) Office Road Suite 101 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Beatrice Virginia Johnson 0 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO If Under 1 Year If Under 24 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Min. Director 218-24-2583 1 M 2 XF 86 7-10-1926 MD 28a-f show 10a, State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 1 Yes 2X No Somerset Upper Hill 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral g 27849 Jim Moore Road 21867 IISZ 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 SpecifyBlack 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Foster Grandparent Shore Up! Inc Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Issac J. Handy Blanch E. Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy Johnson/Son 30593 Circle Drive, Princess Anne, MD 21853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ò Department of Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) Handy Family Cem 10-2-2012 Upper Hill, MD ²² Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Home Salisbury, MD 21801 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a /a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-trensit Exam or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 1 Yes 2 D 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No 1 ☐ Yes 2 No as case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 X ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 29a. Certifier 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) D-71972 9/25/12 MD 30 Name and address of pels ompleted cause of death (Item 23a) (Type, Print) 951 Hermon Rd, Salisbury SHOK A· BDUL MT 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September Day 29, 2012 Physician/ 3:00 A M Paul KREMENS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Howard 4b. City, Town, or Location of Death Examiner Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 206-26-2896 1 M 2 D F Director Pennsylvania June 1, 1934 78 Usual Residence of Decedent ral", or items 23e or 28e-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Howard Ellicott City Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States Funeral 21042 4308 Buckskin Wood Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No \$ Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white If Yes, Give "natural", 3 Divorced 4 Divorced Completed Year or Dates the Wedical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Electrician permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be 17 Father's Name (First Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Eve ပ William Kremens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 383 Lakeside Rd., Unit 102, Ardmore, PA Sharon Kremens, Wife 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/03/12 Egg Harbor Twp., 4 ☐ Donation 5 ☐ Other (Specify) Beth Kehillah Cemetery 21. Sign that of Fugeral dervice the London 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burner man Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 f yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ■No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No ours after death. eral Director: After this certifics filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 2 1 No Dice 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

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completely filled Medical 1 Crutifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Gentrying Frightian. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Gentrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Gentrying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the 29b. Signature and title of artifier

State Registrar 31 Date filed

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Registrar's Signat

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death r 26, 2012 Physician/ Tadesse Keraga 9:35p M September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death House Casey Rockville Montgomery Social Security Number 212-69-2708 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours (Month, Day, Year) Director 55 Yrs. 1 5 M 2 D F Ethiopia Aug. 15, 1957 10a. State M D 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Merylend or than "netural", or itams 23s or 28s-f sho the Medical Examiner must be notified at Director Montgomery Burtonsville 1 2 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code Funeral 3601 Linganore Way 20866 within 72 hours efter deeth Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 🙀 Married ፩ Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No Specify. 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 4yrs Elementary/Secondary (0-12) Transportation School Bus Driver itam 27 is marked othe other trsumatic event, Be Pege 1 and 2 should be filed v mant of Heelth end Mentel Hy; ent: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Woldemariam Keraga Dinkinesh Negash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zenash Abera / wife 3601 Linganore Way, Burtonsville, MD 20866 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛂 Burial 2 🗌 Cremation 3 🗌 Removal from State ៦ 9/29/2012 Germantown, MD Department
Important: Il
Iny injury or All Souls Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service License 7400 Georgia Avenue, NW, Washington DC 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attanding Physicien: The lew requires that the deeth certificate be axecuted that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospitel or Attanding Physicien: The lew requires that the deeth certificate be axer within 24 hours effer deeth.

To the Funeral Director: After this certificate hes been signed by the attending physicien a gompletely filled in by the funaral director, pege 2 should be deteched for use es the burleign. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year 5 Other (specify) Day 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Nursing Home 5 Residence 1 Yes 2 🗗 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R143201 27. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Muncaster Mill Road, Rockville, MD 20855 Debrah Miller, CRNP:

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year) 0CT 01 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER 26 2012 Physician/ BARBARA JEAN LEWIS 10:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner OUEEN ANNE'S GRASONVILLE 4001 MAIN STREET . Social Security Number Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 69 Director 219-48-5242 1 □ M 2 X F 07/13/1943 WASHINGTON, DC Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at Director 1 Yes 2 X No COLONIAL BEACH VA WESTMORELAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 22443 UNITED STATES 51 MACEDONIA LANE death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify. "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working ed other than 'event, the Me life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) GROCERY VENDOR RECEIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even မ FRANCES SIMPSON CLARENCE D. FOWLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 51 MACEDONIA LANE, COLONIAL BEACH, VA 22443 MICHAEL S. GREENE / SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CHESAPEAKE CREMATION
CENTER of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 09/28/2012 STEVENSVILLE, MD 5 Other (Specify) Name and Address of Facility
LLOWS, HELFENBEIN
6 SHAMROCK ROAD, 21. Sign were of June al Salvy e Licenses HOME, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Year Other (specify) Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6X Other (Specify) 횬 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 7. Magner of Dea 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending
Investigation injury Natural Accident after death Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after
To the Funeral Direct
completely filled in b City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 2 D39505

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

SEP 28

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32. R gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mospital Por, Glan Burnie, MD. 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hvoiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ SEPTEMBER 25 2012 5:35 P M MARY LINDA LEE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min (Month, Day, Year) 212-40-9580 Director 1 🗆 M 2 🗶 F 70 03/25/1942 MARYLAND Usual Residence of Decedent 28a-f show 10d Inside City Limits at 10a. State 10c. City. Town or Location with the Maryland Director notified 1 Yes 2 X No OUEEN ANNE'S CHESTER MD 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? ö ms 23a or Funeral 200 GREEN LEE ROAD 21619 UNITED STATES items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian is marked other than "natural", or item 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2X No Specify: If Yes Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other transponent ဂ GLADYS VICKERS CHARLES WILLIAM COX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 GREEN LEE ROAD, CHESTER, MD 21619 THEODORE LEE / HUSBAND altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date CHESAPEAKE CREMATION CENTER 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09/27/2012 STEVENSVILLE, MD FELLOWS, HELFENBEIN 106 SHAMROCK ROAD, 21. Signature of Funeral Service N & NEWNAM FUNERAL CHESTER, MD 21619 23a. Part 1. Enter the disease, or carriplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Aute Immediate Cause (Final Pu. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it immediate cause. Enter Underlying Examiner Due to lor as a consequence of attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) ed by the at detached for Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Ves Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page 2 1 Yes 2 No this certificate Yes 2 No or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 2 No 1 Impatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After the Funeral Director. Natural injury 5 Pending Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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30. Name and address of person who com

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ed cause of death (Item 23a) (Type, Print)

Registrar's Signature

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2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09719/2012 JIAN GUC LIN 4:30 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Genesis Shady Grove Nursing Home Montgomery 5. Social Security Number 6 Sex Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min. 122-76-3096 Director 1 X M 2 □ F 03/19/1932 China 80 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner myst by notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director North Potomac MD Montgomery 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a Funeral USA 20878 14509 Settlers Landing Way 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", Specify: Asian 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education School Principal vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Datong Lin Meigao Zhang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Hai Lin/son 14509 Settlers Landing Way, North Potomac, MD 20878 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any Injury or otl 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other placel 4 Donation 5 Other (Specify) National Memorial Pk :09/23/2012 Falls Church, VA 21. Signature of Funeral Service Licens 22. Name and Address of Facility Snowden Funeral Home 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 6 MONTINS Physician/ Colon Cancer - Metastatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ie attending physician and Cause (Disease or injury that initiated events resulting in death) Last certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day signed by the at Id be detached for Yes 2 No g 🗍 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown page 2 should A Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 X No certificate 1 ☐ Yes 2 No Division of Vital | funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death.
To the Funeral Director: After it 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 □ Yes 2 □ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, dueth occurred at the time, date and place, and due to the cause(s) and manner as stated. (Charle Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BRY 09/19/2012 D28656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15245 Shady Grove Road, #130, Rockville, MD 20850 Ravi Passi, MD 31. Date filed (Month, Day, Year) State SEP 2 6 2012 Registrar

DHMH 17 Rev 06-2011

Joshua	Michael	Lopez
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State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Y September 23, 2012 0233 hrs **Medical Examiner** Joshua Michael Lopez 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Baltimore County** front of 7803 Seaside Drive Dundalk 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours 637-12-8344 Director 1 X M 2 F 22Yrs. 03/06/1990 Country) Texas Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f shnw e notified at once. 1 X Yes 2 No Texas Galveston La Marque filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 77568 United States 1408 Brazos Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 2009- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status Examiner must be White, etc. 1 Never Married 2 Married 1 X Yes 2012 Specify: Multi-Racial 1 X Yes 2 No specify: Mexican If Yes, Give Year 3 Widowed 4 Divorced É 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 ho
Department of Health and Mental Hygiene.
Impurtant: If item 27 is marked other than "an
injury or other transmant event, the Medical Exa Elementary/Secondary (0-12) College (1-4 or 5+) USN Quartermaster 12 Com 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å La Tosha Williams Michael Anthony Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1408 Brazos Ave., La Marque TX 77568 <u> Michael Anthony Lopez - Father</u> 20c. Location - City o: Town, State 20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State crematory or other place) 0/01/2012 Houston, TX 4 Donation 5 Other Specify. Houston National 22. Name and Address of Facilify 21. Signature of Funeral Sergige Licensee Thibadeau Mortuary Service, P.A.

MD00956

The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart MD 20877 23a. Party. Enter Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Gunshot wounds (2) to head and neck Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical g physician a UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the attending properties of the second 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by the Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been I director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 ER/Outpatient 3 Other 4 Nursing Home 5 Residence 6 ✔ Other: Scene DOA 1 Yes funeral After t 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury Sep 23, 2012 Subject shot by police 0209 hrs Natural 5 Pending 1 Yes 2 ✔ No Director: Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 Could not be Suicide or Town, State) front of 7803 Seaside Drive, Dundalk, MD within 24 hours a To the Funeral I determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 September 23, 2012 O.C.M.E. 30. Name and address of person willo completed cause of diff th (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) alle. 32 Registrar's Signatu State 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month ROBERT 09 LEE LANDON, JR. 201 Medical **Examiner** Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death 9 icomic 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) (Month, Day, Year) 216-56-0936 **Director** 1 🔀 M 2 🗆 F 59 Yrs 1953 Maryland Aug. 27, Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1X Yes 2 □ No Snow Hill Maryland Worcester 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funera 501 Maple Street - Apt. 408 USA 21863 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ō þ 1 Never Married 2 Married 2 X No Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify White Specify: "natural", Completed 3 Widowed 4 X Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hotel 10 Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ည pe Betty J. Roach Robert Lee Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 1407 Snow Hill Lane - Pocomoke, MD 21851 Michael A. Landon (Brother) other Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State ō injury Crematory of Delmarva 9/17/2012 Delmar, DE 4 ☐ Donation 15 ☐ Other (Specify) Signature of Funeral Service Licenses

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME Bai Main Street - Crisfield, MD 21817 306_W._ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attendion physician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician the for use as the buriar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nonknown 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of perforn death? 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No funeral director, Be 26. Place of Death (Check only one) Hospital မ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending eral Director: Al filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29c. License number 29d. Date signed (Month. Day. Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Mo

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State of N	/larylan					and M	lental Hy	giene	€		
		Registrar 1. Decedent's Name (Fin	ret Middle I as	<i>†</i>)		(Certificat	e of L	Death	_	0 0-460	Reg. N	· 20	12	3325
Physicia Medic		REVA		SABE	LLE		LAR	6E	N		2. Date of De		5,20	12	3. Time of Death A 0415 M
Examin	er —	4a. Facility Name (if not	Menio	CENE			F	AZ	r Location	WN			Nos 11	15Te	N
Funeral Director		5. Social Security Numb	2	7. A	ge (In yrs. Ia	st birthd	Months	Days	If Under Hours	Min.	8. Date of Bii (Month, Da 04/26)	rth 7, Ye <i>ar)</i> 194	7 9.1	Birthplac Country	ce (State or Foreign Maryland
und show at	'n	Usual Residence of Dec 10a. State 10a	b. County		10c. Cit	y, Town o	r Location								. Inside City Limits
Aaryla 8a-f s tified	Funeral Director	Maryland N	Washing	ton	C1e	ar S	pring								1 🗌 Yes 2 🕱 No
n the last	al Di	10e. Street and Number	r		-		10f. Zip	o Code				10g. Citizen of What Country?			
th witl ms 23 must	ner	13128 Broa	adfordi					2172					S.A.		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status1 Never Married3 Widowed 4 		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S ? No	5.	13. Was Deced If Yes, spec 1 \(\sum \) Yes				cify Yes or No∙ Rican, etc.)		14. Race - Ai Black, Wi Specify: W	hite, etc	•
2 hour "natu edical	plet		5. Decedent's Econly highest gra			16a. Do	ecedent's Usu Give kind of wo	al Occup	ation	t of worki	na	16b. I	Kind of Busine	ss Indus	stry
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n 24 hou	Medical	(Check 2 🗌	Medical Exami	ician: To the best oner: On the basis of e Practioner: To the	examination	and/or in	vestigation, in	my opinio	on, death or	curred at	the time, date a	and place	e, and due to th	e cause	(s) and manner stated.
To th comp		29b. Signature and title		,					number	-1			ite signed (Mo.		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												06/20	0/2		
1111		30. Name and address of Mork Ry 31. Date filed (Month, Da	ARAN	M.O., N	1er.k	5M	ed (Co)	Con	Ter, 1	409	Tolot	off	co HE	زعها	Town, MP
Stat Registra			1 6 2012	. Regist	rar's Signat	ure	n Ked			*			/		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, County of Death 4b. City, Town, or Location of Death Examiner Drive OAKCAN If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) **Director** 217-30-1634 Usual Residence of Decedent 1 🕅 M 2 🗆 F 78 Maryland 11/30/1933 28a-f shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 U.S.A. 422 Sonny Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ 1 X Yes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Truck Driver Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Leighton Ellen Reams Russell Harland Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 422 Sonny Dr., Oakland, MD 21550 Mary E. Leighton/ Wife 20a. Method of Disposition 20b Place of Disposition (Name of Contain) Life by Latery and Commer place; 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State 9/29/2012 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) Crematory 22. Name and Address of Facility Newman Funeral Hoes, P.A. 203 S. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licenses Second St., 23a. Part 1. Enter the disease, or complications that eaused dsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Artemosclerotic Couman disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury Due to or as a consequence of Exam the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year been signed by the a should be detached Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed eral Director: After this certificate I filled in by the funeral director, pag 2 🗌 No 1 🗌 Yes Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 🗌 No Other: မ 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending hours after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 - Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 8:16 P Rosie Helen McLucas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Retirement Center Washington Williamsport If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex . Age (In yrs. last birthday 8. Date of Birth **Funeral** Months Sept. II, 1925 Pennsylvania 87 201-16-7133 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1X Yes 2 ☐ No Williamsport Maryland Washington Ξ 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be i Funeral 18 North Vermont Street Apt. Al 21795 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Albert any injury or Albert 27. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?.
1 ☐ Yes 2 🗷 No þ 1 Never Married 2 X Married Yes 1 Yes 2 No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Garment Manufacturer Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည David L. Rhines Nellie G. Schopf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William McLucas - Husband 18 North Vermont St. Apt. Al Williamsport, MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Oct.8,2012 Williamsport, Maryland Greenlawn Mem. Park Funera Circlice Licensee 22. Name and Address of Facility Osborne Funeral Home, P.A. Conococheague St.Williamsport, 425 S. MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month 5 Other (specify) Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No Records, 3 Probably 4 Unknown 1 Yes should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? 1 Yes 2 No this certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: ္ဝ 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: hin 24 hours after death. the Funeral Director: After injury work? Natural 5 Pending 2 🗆 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

580 CMORTHERN AVENUE HAGERSTOWN MO 2742

1)0063233

10/4

Shahid Mahmood,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .2<u>012</u> Physician/ Nelson Morataya 2313 Juan Sept.24 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 6/12/1961 Honduras 219-21-3503 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director Columbia MD Howard 1 ¥ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21055 8778 Tamar Drive death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 No þ Baltimore, Maryland 21215-0036 hours after 1 🕏 Yes 2 🗆 No Specify: Honduran White If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction 12 Self employed Be 18. Mother's Name (First, Middle, Maiden Surname)
Tomasa Alvarez 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. ည Luis Alfonso Morataya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8778 Tamar Drive Columbia, Md. Diana I.Morataya/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/28/2012 Silver Spring, Md Gate of Heaven f Funeral Service Li 21. Signatur PHILIP D.RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of). sician and e burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): inding physician ause as the burial-Physician/Medical Box 68760 use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Day Pregnant at time of death Other (specify) Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | þ Records, 1 ☐ Yes 2 😾 No 3 ☐ Probably 4 ☐ Unknown Completed Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe page 2 certificate Yes 2 No **Division of Vital** To the Hospital or Attending Physician: 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? released Other: ဂ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Agent Agent After Agent After Agent After Agent injury 5 Pending Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

11055

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

3. Registrar's Signal

Price

Michelle

27

31. Date filed (Month, Day, Year,

September 26,2012

Little River Parkway #104 Columbia, Md

12-07415 Sai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ire, MD 21215-0036 s I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she her traumatic event, the Medical Examiner must be notified at once To Ba Completed by Funeral Director		aurino Vi				19b. Mairing	Address	(Street	and Numb	per or Rural	Route Nur	nber, City or	r Town, State,	, Zip Code)	
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Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	21. Sign	Donation 5 Other S parture of Funeral Service	e License			22t N	ame and	Address	of Facility	T.D.T	FUNE	RAL S	SERVI	CE,P.A	
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Physician.	23a. Pa	art I. Enter the disease, of flure. List only one caus	or complications to e on each line.	hat caused	the death.	Do not enter to	he mode of	ayıng, s	such as ca	ardiac or res	spiratory an	631, 3110014	or riour.	Between C	nset and
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Division of Vital Records, P.O. Box 68760 tal or Attending Physician: The law requires that the death certificate b as after death. 34 Director: After this certificate has been signed by the attending physicate in by the funeral director, page 2 should be detached for use as the but	2	Suicide 6 C	ould not be 286	e. Place of I	Injury - At h	nome, farm, str	eet, factory	, office I	building, e	etc. 28	or Town		, Number or K	(urai Route ive	iniber, only
Division of Vital Records, P.O. Box 6 ospital or Attending Physician: The law requires that the death cer hours after death. uneral Director: After this certificate has been signed by the attendity filled in by the funeral director, page 2 should be detached for use	Certification:	Homicide		pecify)						leas and di	up to the ca	use(s) and t	manner as st	ated.	
Hos Pun ely		Certifier 1 Certifying	Physician: To i	he best of r	my knowled amination	dge, death occ and/or investig	urred at th ation, in m	e time, d iy opinioi	n, death o	ccurred at t	he time, da	te and place	and due to	the cause(s)	
Tn the within 2 To the complet	교	Signature and title of ce	and me	nner stated	1	,			se number			29d. Da	ate signed (M	fonth, Day, Yea	ar)
perop	290.	O.C.M.E. October 2, 2012													
Che D	20. 1	ame and address of per	son who complete	ed cause of	death (Ite	m 23a)									
		ame and address of per abiullah Ali, M.D.	Assistant I	Medical E	Examine	er 900 W.	Baltimo	re Stre	eet, Bal	timore, N	AD 2122	3			
St		Pate filed (MON Pay()	5 2012	32. Regist	rar's Signa	ature	العثاما					-			
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Physiciar edical Examin	n/	-For State Certificate of tegistrar 1. Decedent's Name (First, Middle,Last) Rocio Nikaury Marcello Nikaury	Morce:	lo	Reg 2. Date of Death Month I September	. No.	3. Time of Death 0337 hrs				
garoar Examin		4a. Facility Name (if not institution, give street and number) 2213 Georgian Way	4b. City, Town, o Silver Sprir	r Location of Death	Сертенные	4c. County of Dea					
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 101-72-1175 1 M 2 K F 37 Yr	Months Day		8. Date of Birth 06/24/1	(MM/DD/YYYY) 9. E .975	Birthplace (State or Bigh Dominican Country) Republic				
Aaryland 28a-f show any 1 at once,	Director	Usual Residence of Decedent 10a. State			100	g. Citizen of What Co	10d. Inside City Limits 1 Yes 2 X No				
the h	Funeral Dire	1 Never Married 2 Married Armed Forces? If		ispanic Origin? (Spe in, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	United Sta	american Indian, Black,				
"natural", ur	ᇍ	15. Decedent's Education (Specify only highest grade completed) 16a. Decede				Specify: Wh:	s/Industry				
p, MD 21215-0036 and 2 should be filed within 72 hours af feath and Mental Hygiene. Item 27 is marked other than "natural traumatic event, the Medical Examin	\sim 1										
MD 2121 nd 2 should be fill and Mental m 27 is marked summatic event,	To Be	, , , ,			ural Route Numb	er, City or Town, Sta	ate, Zip Code)				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: Atlantic	esition (Name of co ther place) Cremato:	ry 09/2	Date 27/2012	20c. Location - City Glen Buri					
Balt Permit. Departi Import		21. Signature of Funeral Service Licensee 22. Th MD00956 7 23a. Part I. Atter the disease, or complications that caused the death. Do not enter	Park Ave	ss of Facility Mortuary Gaithe , Gaithe	rshure.	MD 20877	Approximate Interval				
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sharp Force Injuries Due to (or as a consequence of):					Between Onset and Death				
cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): d.									
E 5 VE	Medical										
Box 68 ne death certif the attending hed for use as	Physician	past 12 months? 1 Yes 2 No 9 V Unknown 2 Pregnant at time of death 5 0 Unknown	Other (Specify)				Day Year to the cause of death?				
ds, P.O.	<u>ā</u>	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	given in rait i.	1 Yes	2 ✓ No 3 Pi	robably 4 Unknown autopsy findings available o completion of cause of				
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Division spital or Atter cours after dear need Director filled in by the	E a sea Commode										
To the Hos within 24 h To the Fur completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investig and manner stated. 29b. Signature and title of certifier	ation, in my opinio	date and place, and on, death occurred at nse number	due to the cause t the time, date a	(s) and manner as sind place, and due to 29d. Date signed (M	the cause(s)				
7		30. Name and address of person who completed cause of death (Item 23a)	0.0	.M.E.		September 23,					
Sta	ate rar	Melissa Brassell, MD Assistant Medical Examiner 900 \ 31. Date filed (Month, Day, Year) SEP 2 6 2012		Street, Baltimor	re, MD 21223						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For		State of	Mary		•			and N	nental H	ygien		110	0.0	220-
			State Registrar					Certifica	ate of L	Death			Reg. i	No. 2) 2	3	3267
	Physicia	m/	1. Decedent's Nar	me (First, Middle,	Last)			•				2. Date of D				3. Time	of Death
	Medic		Sylvia	S. Mar	iano							Month Septeml	ber	26, 2	Year 2012	10:	50 a™
	Examin		4a. Facility Name	(if not institution,	give street and numb	oer)		4b. Ci	ty, Town, or	r Location	of Death			4c. County			
and a			Suburban	Hospit.	a1			Bet	thesda	а				Mont	omer	v	
1	Funeral		5. Social Security	Number		7. Age (In y	rs. last birth	day) If Und	der 1 Year	If Under		8. Date of B	irth		9. Birthr	olace (State	or Foreign
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	the l		10e. Street and Nu	umber					Zip Code				10g. (Citizen of V	What Cour	itry?	
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	eath tems er m	Funeral Director	11. Marital Status		12. Was Deced	lent Ever in	U.S.	13. Was Dec			igin? (Spe	cify Yes or No Rican, etc.)			e - Americ		
9	or i	b	1 🗌 Never Ma	rried 2XX Marri		2 X No						Rican, etc.)		Blac	k, White,	etc.	
03	saft ral", Exa	- P	3 🗌 Widowed	4 Divorced	If Yes, Give Year or Dat			1 \square Yes	2XXNo	Specify.	:			Specify:	Paci	fic I	slande
0-0	hour natu lical	Completed		15. Decedent	t's Education		16a, E	ecedent's Us	sual Occupa	ation			16b.	Kind of Bu	ısiness/Inc	Hustry	
21.5	n 72 an " _I Med	m d	(Sp Elementary/Sed		st grade completed)	1075.)	(0	Give kind of v fe. DO NOT u	vork done d ise retired)	during mos	st of workii	ng	100.	Tana or Be	3011000/1110	adotty	
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<u>a</u>	be f lenta rked ic ev	욘	Cirilo	Solitari	Ĺo							cia Bac			,		
Maryland 21215-0036	nd M nd M mal		19a. Informant's N	Name/Relationshi	ip (Type, Print)		19h	Apiling Addre	es (Straat s			l Route Numb			toto Zin C	anda)	
Š	2 st Ith a 27 is trau				ano/Husban	1											
(ပ်	and Hea tem		20a. Method of Dis		mo/ nusban			isposition (N		tree		Llver S		ng M Location -			
10	nt of nt of t: If i		1 🖾 Burial 2	2 Cremation	3 X Removal from S	State	cemetery,	crematory of	r other plac	:e)	Oct.		1		•		
章	it. Pa rtme rtani rtani			n 5 ☐ Other (Sp		Га	Loma	Cemete	Tic		20	012				, Ph11	ippines
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	1111 -	censee Vatu			Franci	and Addres	ss of Facilit	ins E	uneral	L Ho	me In	ic.		
_	42240	_	am	()	- ()			<u>500 Un</u>	ivers	sity]	Blvd.	W., S	Silv	er Sp	ring	MD 2	20901
			23a. Part Lenter shock, or he	the disease, or o art failure. List or	complications that ca nly one cause on each	used the d	eath. Do not	enter the mo	ode of dying	g, such as	cardiac o	r respiratory a	arrest,			Approxima Interval Be	
9	h, sician/	a s	Immediate Cause disease or conditi		Anasa	rca										Onset and	
	Medical		resulting in death)		a.		equence of)	:									
	Examiner		Campandinii, link		Sever	e Con	centr	ic Lef	t Ven	itrici	ular	Hypert	ropl	hv			
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	:E 70 66																
_ 88 ·	death certiff ne attending ed for use a	2	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outco									23d Dat	e of delive	ID/	
o Am Box 6	atte afte for	icia	in the past 12	months?	1 ☐ Live Bi 4 ☐ Pregna			3 Cectopie 5 Other (У				Mor			Year
	ne de / the chec	ys	9 Unknow		9 🗆 Unkno	wn			, ,,								
1 tar 0:51 ds, P.0	law requires that the death certifias been signed by the attending a 2 should be detached for use a	Completed by Physician/N	Part II. Other signi	ificant condition	ns contributing to dea	ath but not	resulting in	he underlying	g cause giv	en in Part	1.	23e. Did 1	tobacco	use contri	ibute to th	e cause of	death?
1+0 0: 1s, 1	requires the been signer should be a	d b	Monoclor	nal Gamm	opathy of	Unde	rdete	rmined	Sign	ifica	ance.	1 1 1	Yes :	2 □ No	3 Prob	ably 4 🔀	Unknown
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00e	law has l	ldu	Renal Fa	allure								24a, Was auto	psy	р	rior to cor	sy findings npletion of	available cause of
, 48 B	The la	S										1 Tes	ormed? 2 😾 l		leath?	2 🗆 No	
Sylvia. 2012 of Vital R		Be	25. Was case reference examiner?	red to medical					26. Pla	ace of Deat	th (Check	only one)					
5 4 ≥	hysic nis ca	ျ	1 🗌 Yes 2	™ No	Hospital:	patient 2	☐ ER/Outp	atient 3 🗆	DOA Othe	er: 4 🗌 Nu	ursing Hor	me 5 🗆 Resi	idence	6 Othe	r (Specify)		
Sy of	ding Ph h. After th funeral	ië.	27. Manner of Deat XX Natural	th 5 Pending	28a. Date of	injury , Day, Year)	28b. Tin		28c. Injury work		2	8d. Describe	how inju	ry occurre	ed .		
26 26 on	endii sath. or: At he fu	lica	2 Accident	Investiga	ation	,,,,	","	M		Yes 2 🗆	No						
n C isi	er de recto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no determin	28e. Place o			, street, facto	ory, office		2	28f. Location (r or Rural	Route Num	ber,
Mariano, Sept. 26	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the				ballang	g, etc. (Spec	City)					City or To	wn, Stat	e)			
73	boun houn houn ify fill	Medical	29a. Certifier	1 Certifying F	Physician: To the bes	st of my kno	owledge, de	ath occurred	at the time	, date and	place, and	d due to the c	cause(s)	and manne	er as state	d.	
la S	ne Hu n 24 ne Fr	Med	(Uneck	≥ □ Medical Ex	aminer: On the basis Nurse Practitioner: 1	of examina	ation and/or i	rvestigation, i	n mv opinio	n, death oc	ccurred at t	the time, date :	and place	e and due	to the cau	se(s) and ma	anner stated.
\mathcal{L}	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	-	29b. Signature and		= //				c. License					ate signed			
	6			1	TX				D681	160				ept.			
	4	-	30. Name and add	ress of person w	ho completed cause	of death /It	em 23a) (Ty	ne Print\						- r - ·			
			Kimberly						n Rose	d. Ro	thes	da, MD	208	814			
	Stat	e	_			jistrar's Sia	ınatı ∉ e	1 .0	1.04	, DC	1100	uu g III	200				
	Registra	r	31. Date filed (Mon	CT 012	1012 Cen	un	1. 1	barles	0.75								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:45A M 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nursing George Home Forestville 8. Date of Birth (Month, Day, Year) g. Birthplace Country) 6. Sex 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. (State or Foreign **Funeral** Director 30 -1 M 2 X F 87 Marylan 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Funeral Director 1 Yes 2 No Prince Maryland 0 10g. Citizen of What Country? 23a 20747 orestville "natural", or items Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 3 Widowed 4 Divorced Black Year or Dates Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) injury or other traumatic event, the Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be file ment of Health and Mental tant: If item 27 is marked o ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Art 202 Rd Marshall Forestville 4355 MD Elizabeth 1) Ayento Jepartment of Heal Important: If item 2, any injury 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date Burial 2 Cremation 3 Removal from State Maryland 5/2 Other (Specify) 10-6-12 21. Signature of 22 Name and Address of Facility MI 20608 a. Part 1. Enter the disease, or complications that caused the death o not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death nediate Cause (Final 050 Drova scylax Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical death certificate be Box 68760 the as 1 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months of for Month Day Year Pregnant at time of death 9 Unknown Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Records, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed 2 1 No certificate Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) in 24 hours after death. he Funeral Director: After this opletely filled in by the funeral of Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Certificate: Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier 0070693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

OCT O

1AHBOOB

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33269 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Frank Wayne Michaels 0704 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WM Regional Medical Center Allegany County Cumberland Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Min 215-56-7809 Hours Director 1 🛛 M 2 🗆 F 62 May 21 1950 Maryland show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Allegany 28a-f Westernport 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21562 206 Baughman St. United States or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Church Minister Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Luhter Michaels Rosie Ross 19a. Informant's Name/Relationship (Type, Print)
Mary Michaels/ wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Baughman St, Westernport, Maryland 21562 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Westernport, Maryland Department of H Important: If ite any injury or ot 10/05/2012 1 M Burial 2 Cremation 3 Removal from State Philos Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Preumonia Physician/ Aspiration Medical resulting in death) Due to (or as a consequence of) Examiner Urinary mach intechol. Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 use as the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year signed by the a Yes 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanced multiple Scienosis Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed decubitus vicers 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? Yes 2 No Chronic ostcomyelihis of Sacrum 2 🗌 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☑ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

 Hospital or Attending Physician: The 24 hours after death.
 Funeral Director: After this certificate b the within To the

29a. Certifier

(Check

29b. Signature and title of certifie

und address of person who completed cause of death (Item 23a) (Type, Print)

Venumadhar Chirunomula, 12501 Willowbrook RD, Cumberland, MD 21502 31. Date filed (Month, Day, Year) Registrar's Signature

State Registrar Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0074399

29d. Date signed (Month, Day, Year)

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Bernard Harold Michael Physician/ October 2 pay 2012 ear 4:30 A M Medical 4a. Facility Name (if not institution, give street and number)
Egle Nursing and Rehab Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany County Lonaconing If Under 1 Year If Under 24 Hrs. 8. Date of Birth Aug. Pay, Year Aug. 1922 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Numbe 231–14–6009 7. Age (In yrs. last birthday) Funeral Days Hours 90 Director 1 X M 2 □ E i and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It was 23a or 28a or 28a f show other traumatic event, the Medical Examiner must be postified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Westernport 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21562 255 Wood St. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Black, White, etc. ò WW 2 1 Never Married 2 🔀 Married 1 ☐ Yes 2 🔀 No Specify: _{Specify.}white 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Paper Manufacturer Finisher Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ္ဝ Edward Michael Clark Elsie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Michael/ wife 255 Wood St, Westernport, Maryland 21562 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/02/2012 Morgantown, WV WV Human Gift Regis. 4 X Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVASCULAR ACCIDENT Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 PNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at/ 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DCTOBER 02, 2012 Thour 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar	1 4)		Ce	rtificate of D	eath	2. Date of De		012	
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	Medic		Margaret He 4a. Facility Name (if not institution				4b. City, Town, or	Location of Deat		ber 24,	2012 ty of Death	9:45
	Examin	er			_				•••		erset	
tagen of	Funeral		8911 Millard 5. Social Security Number	Long Road 6. Sex	7. Age (In yrs.	last birthday)	West of Under 1 Year	If Under 24 Hrs		th	9. Birthp	lace (State or Foreign
	Director		219-03-6267	1 □ M 2 🛛 F	92	Yrs.	Months Days	Hours Min.	. (Month, Da 05/22/		Count	ryland
	D 80		Usual Residence of Decedent 10a. State 10b. County		1	ity, Town or Le	ocation		03/22/	1520		0d. Inside City Limits
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	ems ems	١ڐ	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of Hi				ace - Americ	
0	or It	by	1 Never Married 2 Ma	ried Armed F	2 K No		If Yes, specify Cubar	Specify:	to nican, etc.)	Speci	lack, White, 6	
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ס מ	Hygi othe	Be	17. Father's Name (First, Middle,	Last)		1 110			ame (First, Middle	, Maiden Surna	me)	
<u>ja</u>	l be fi fental rked tic ev	잍	George Joynes					Beula	h Maddox	<u> </u>		
Maryland	should be filed with and Mental Hygier is marked other t raumatic event, the		19a. Informant's Name/Relations			19b. Mai	ing Address (Street a	and Number or Ri	Pural Route Numb	er, City or Town	, State, Zip C	Code)
2	O = 5 =		Margaret L. P	ope/Daugh	ter	89	ll Millard	d Long R	d., West			
ore	of Her		20a. Method of Disposition 1	3 Removal fro		Place of Disp cemetery, cre	osition (Name of ematory or other plac		Date	20c. Locatio	n - City or To	own, State
Ĕ	. Pege tment c tent: If jury or		4 Donation 5 Other		Sar		ley Cemeter		29/2012		over,	
Baltimore,	permit. Pege 1 and 3 Depertment of Healt Importent: If item 2 any Injury or other once.		21. Signature of Funeral Service	censee	OP	1	Name and Address Stewart F 821 West	uneral I Rd., Sa.	Home by lisbury,	Hollowa MD 218	y and	Downey, P.A.
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	Medical Examiner		resulting in death)	Due to	o (or as a conse		7		1	10000		
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8	endin r use	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of pregi		☐ Ectopic pregnand	у			Date of deliv	
P.O. Box 687	death he att ed fo	sici	in the past 12 months? 1 Yes 2 No	4 ☐ Pre 9 ☐ Un	egnant at time o known	f death 5	Other (specify)				Month	Day Year
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Vita	yslcle s cert direct	To Be	examiner? 1 ☐ Yes 2 🗡 Ne	Hospital:	Inpatient 2	☐ ER/Outpat	ient 3 DOA Oth	er: 4 Nursing	Home 5 KRes	sidence 6 🗆 C	ther (Specifi	y)
of	ig Phy ter thi neral		27. Manner of Death 11 ✓ Natural 5 ☐ Pend		te of injury onth, Day, Year)	28b. Time injury			28d. Describe	how injury occ	urred	
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Division of Vital Records,	or Att	Certificate:		minod 28e. Pla	ce of Injury - At Iding, etc. (Spec		street, factory, office			(Street and Nur own, State)	nber or Rura	l Route Number,
۵	ours a		29a. Certifier 1	ng Physician: To the	best of my kno	wledge, deat	h occurred at the tim	e, date and place	e, and due to the	cause(s) and m	anner as sta	ted.
	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burlai-transi	Medical	(Check 2 Medical	Examiner On the h	asis of examinat	tion and/or inv	estigation, in my opini ge, death occurred at	on, death occurre	ed at the time, date	and place, and	due to the ca	ause(s) and manner stated.
	within To the comp	2	29b. Signature and title of certifi		/	,	29c. Licens			29d. Date sig		
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	1000		30. Name and address of perso		ause of death (It		, Print)					4415
)	KOS		RONALD				1665 W	OODBRO	ook Dr	SALI	SOUR	x MD 51804
	Sta Registi		31. Date filed (Month, Day, Year) SEP 2 8 2012	Marie 32	. Registrar's Sig	nature					(
	negisti	(ell	JET WU LUIL	A Partie								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2012 Sept. 12, 1:40A RICHARD ARLAND MISTER /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2 □ F Yrs. 212-40-9860 70 Director June 4, 1942 Maryland Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 No Director Crisfield Maryland Somerset 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 7 must be n 2 Village Drive - Apt. 12 21817 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or item edical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygient Important: If Item 27 Is marked other tha any injury or other traumatic event, the in once. 8 Assembly Worker Cutlery Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Mister Florance Landon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holly Kauffman (Daughter) 26467 Mariners Road - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 9/13/2012 Delmar, Delaware 21. Signature of Funeral Jensus January Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main St. - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: After this c funeral dire 1 | Inpatient 2 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

within 24 hours after death.

To the Funeral Director: / To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O Via Y Your Naurallanzon Hall Highway - Crisfield, MD 21817 31. Date filed (Month, Day,

32. Redistrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 48098

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10702/2012 20:12 Dorene Ann Mulzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2551 Baltimore Blvd., Lot 66 Finksburg Carroll . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Director 274-42-3653 1 □ M 2 💢 F 67 05/16/1945 OH "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Finksburg MD Carroll 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2551 Baltimore Blvd., Lot 66 21048 within 72 hours after death with USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian ☐ Yes 2 X No Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Widowed 4 X Divorced Completed White 2 should be filed within 72 hours of the and Mental Hygiene.
27 is marked other than "natural traumatic event, the Medical Extramatic event, Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) cook restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Mulzer Lucille McCarty rmit. Page 1 and 2 should be partment of Health and Ments portant; If item 27 is marked by injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracie Ingle/daughter 30 W. Green St., Apt. 4, Westminster, MD 21157 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 10/08/2012 Hampstead, MD 22. Name and Address of Fpritts Funeral Home and Chapel PA . Signature of Juneral Service Lig V--1 412 Washington Road, Westminster, MD 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of Injury that initiated events resulting in death) Last nding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ☐ Live Birth 2 ப reख மக்க ☐ Pregnant at time of death in the past 12 months? ò Month Year the a g 🗌 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Smohr Division of Vital Records, Completed 1 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: After din by the fur 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral I

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

f

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

Stephen J. Sikorski

1 6 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's

33576

912 Washington Road, Westminster, MD

29d. Date signed (Month. Day, Year)

21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Mary				/lental Hygie	ene			
			State Registrar	Cer	tificate of L	Death	1	1. No. 2A	12 33276		
ı	Physicia Medic		1. Decedent's Name (First, Middle, Last) James William Newman,	Sr.			2. Date of Death Month 09/29/	/ 2012 Ye	3. Twhe of Death 3 ar 8:47p M		
and the same	Examin		4a. Facility Name (if not institution, give street and number)			r Location of Death		4c. County of [
- Married			3217 Westdale Court		Wald			Char			
	Funeral Director			74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 0 4 / 1 1 / 1	ear)	Birthplace (State or Foreign Country) DC		
	and show	5		City, Town or Loc	cation				10d. Inside City Limits		
	Maryla 28a-f	Director	MD Charles	Waldor	f				1X Yes 2 □ No		
	with the I 23a or 2 ust be no	Funeral Di	3217 Westdale Court		10f. Zip Code 2060	1	100	10g. Citizen of What Country? USA			
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☒Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	l l	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, V Specify:	American Indian, Vhite, etc. American Indian		
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aryl	should be file and Mental F is marked o raumatic eve		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street	and Number or Run	al Route Number, Ci	ty or Town, State	, Zip Code)		
Σ	and 2 sl Health a tem 27 i		Elois Newman/wife	3217	Westdale	Ct. Wald	lorf, MD 2	20601			
Baltimore,	Page 1 ar		1 Removal from State	Ob. Place of Dispo cemetery, cren Resurrec	natory or other plac	etery 10/0		c. Location - City Linton,			
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee				scoe-Toni n RD Wald				
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Test	Medical Examiner		resulting in death) Due to (or as cor	nsequence of):	00						
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Box 6	hat the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnand Other (specify)	су		23d. Date of Month	f delivery Day Year		
-	the a	ıysic	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	e or death 5 L	Uner (specify) _						
, P.O.	Physician: The law requires that the this certificate has been signed by that director, page 2 should be detach	by	Part II. Other significant conditions contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.			te to the cause of death?		
rds	equire seen s hould	eted							e autopsy findings available		
of Vital Records,	sician: The law r certificate has b lirector, page 2 s	Completed				***	24a. Was an autopsy performe	prior d? deat	r to completion of cause of th?		
Ä	n: The ficate or, pa		25. Was case referred to medical		26 DI	ace of Death (Chec	1 Yes	No 1	Yes 2 No		
Vita	ysician: is certific director,	To Be	examiner?	2 ☐ ER/Outpatien	Oth		ome 5 Residence	ce 6 🗆 Other (S	Specify)		
of	ding Phys h. After this funeral d		27. Manner of D ≠th 28a. Date of injury	28b. Time of		y at	28d. Describe how		pedity		
on	Attending or death.	fica	2 Accident Investigation	ary Ingary		Yes 2 No					
Division	al or Att	Certificate:	3 _\Suicide 6 _\ Could not be 4 _\ Homicide determined 28e. Place of Injury - building, etc. (Sc	At home, farm, streecify)	eet, factory, office		28f. Location (Stree City or Town, S		r Rural Route Number,		
_	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my keep to the control of the best of my keep to the best o	nation and/or invest	igation, in my opinio	on, death occurred a	t the time, date and p	place, and due to	the cause(s) and manner stated.		
	Vithii To th	-	29b. Signature and title of certifier		29c. License	e number	29d	I. Date signed (M	onth, Day, Year)		
	2		> Frau		1070	555	7	10-1-	-17		
	De,		30. Name and address of person who completed cause of death	(Item 23a) (Type, F	rint)	valdo	y 180	~D>	0693		
	Sta	te	31. Date filed (Month, Day, Year) 33. Registrar's S	Signature	Kel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amended #8 per funeral nome 10/1/2012/cchd/ba

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Melma Estelle Nanney 11:06 P Sept Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number 8. Date of Birth (Month, Day, Year April 13, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Hours Country) Director 1 - M 2XX 218 16 2057 91 Maryland Yrs. 1921 I Hygiene. other than "natural", or items 23a or 28a-f show rent, the Meslical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b Count 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🔽 No Maryland Prince George's Morningside 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 4502 Maple Road 20746 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give X Black, White, etc. 1 Never Married 2 Married ۵ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 ¬Widowed 4 □ Divorced Completed Year or Date: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th 12 Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Sylvester Tayman Mary Lena Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margrette Nanney (Daughter) 4502 Maple Road, Morningside, MD 20746 or other tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Oct 1, 2012 Suitland, MD 21. Signature of uneral rvice Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Š to mirryle m0139 Ferry Road, Clinton, MD 20735 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 24 hours after death.

9 Funeral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown q | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ₽ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one Certifying Nuyse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and till of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 0 bes 2612011 30. Name and address of person w cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State

Registrar

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Day 30 JOHN FRANCIS O'LEARY SEPTEMBER 2012 1:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BRIGHTVIEW AVONDELL BEL AIR HARFORD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 9. Birthplace (State or Foreign Min. Hours 162-18-8815 Country) Director 1 X M 2 □ F 94 12/12/1917 PENNSYLVANIA 10a. State 10b. County ed other than "natural", or items 23a or 28a-f aho event, the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HARFORD 1 X Yes 2 ☐ No MD BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 128 WEST RING FACTORY RD, APT. 138 21014 UNITED STATES 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black. White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: WHITE 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mentel Hygiene. Is marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) RESEARCH SCIENTIST BIOCHEMISTRY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WINIFRED EMBERT JOHN THOMAS O'LEARY ge 1 and 2 should but of Heeith end Mer: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN POST / DAUGHTER ST. MARY'S ROAD, PYLESVILLE, MD 21132 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place).
PETER'S CATHOLIC
CEMETERY 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ò permit. Pege Depertment of Important: If any injury or once, 10/02/2012 QUEENSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN 106 SHAMROCK ROAD, & NEWNAM FUNERAL HOME, P.A. CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Renal concer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ettending physicien end for use es the buriai-transit or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diaheter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown HRG 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t director, page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No To the Hoapital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 1 ☐ Yes 2 ☑ No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural: 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Down SD D22256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6-5 W. MacPho 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1	For AMEND#26perMD 9/2771 State RegistraMEND #4a,4bperMD,	2; EW, Mode 1	Co Cer	tificate of D	eath Death	R	eg. No.				
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Deat		3. Time of Death /			
* sharing	Medic Examin	al	Jose Santiago Alva 42,328 St. Andrews Ch		nez	4b. City, Town, or	Location of Death	09/1	17/2012 5:59 pm 4c. County of Death				
أمري		13	HOSPICE OF St.	ary s		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	St. Mary's				
L	Funeral Director		5. Social Security Number 578-11-1652 Usual Residence of Decedent	7. Age (In yrs. lat	st birthday) Yrs.	Months Days	Hours Min.	0 8 / 2 2 /	Year)	Birthplace (State or Foreign Country) uatemala			
	show dat	tor	10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits			
	Mary 28a-f	Director	DC	Wa	shin	gton, DC	2			1 Yes 2 No			
	n with the	Funeral D	10e. Street and Number 3115 South Dakota	a Avenue N		10f. Zip Code 20018			Guatema	la			
9800	e filed within 72 hours after death with the Maryland tal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	2	1 X Never Married 2 Married 1	/as Decedent Ever in U.S rmed Forces? ☐ Yes 2 ★No Yes, Give ear or Dates.		Was Decedent of His f Yes, specify Cubar I Ϫ Yes 2 ☐ No			Black, V	American Indian, White, etc. hite			
21215-0036	thin 72 hou ane. than "nat u he Medica	Completed			(Give life. D	dent's Usual Occupa kind of work done d O NOT use retired) Porter	ation luring most of worki	ing		Gind of Business/Industry			
d 2	led within I Hygiene. other than rent, the N	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, N	· · · · · ·				
/lan	iould be file nd Mental I s marked c	입	Rigoberto Alvare	ez			Concepc						
Maryland	should and Me ris mar raumati		19a. Informant's Name/Relationship (Type, Pr		19b. Mailir	ng Address (Street a	and Number or Rura	I Route Number,	City or Town, State	e, Zip Code) 20782			
	1 and 2 should be if Health and Mem item 27 is marke other traumatic		Ervin Alvarez-sor 20a. Method of Disposition	20b. Pl	ace of Dispo	sition (Name of			J Hyact: 20c. Location - Cit	sville, MD			
Baltimore,	Page nent o ant: If ury or		1 🔀 Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	wal from Ctata C6	emetery, crer ily (natory or other place Cemetery	9/2	9/12	Guatema				
Ba	permit. Departr Import any inju		21. Signature of Funeral Service Licensee **Wanda C. Bac	on CC036		147 14th				ral Home C 20010			
	Pnysician/ Medical		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	ns that caused the death se nn each line. Due to (or as a co 150 qu	Neck	- 1	g, such as cardiac d	or respiratory arre	est,	Approximate Interval Between Onset and Death			
1.00 m	Examiner	Į.	Sequentially list conditions, b. —										
	pa; t	mine	cause. Enter Underlying Cause (Disease or injury	Due to or as a conse u	ence oij:								
	icate be executed physician and is the burial resist	edical Examiner	that initiated events C. — resulting in death) Last	Due to (or as a consequ	ence of):								
092	ate be physicia the bu	dica	d										
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	yes, outcome of pregnar Live Birth 2 Feta Pregnant at time of d Unknown	I death 3	Ectopic pregnanc Other (specify)	у		23d. Date of Month				
ls, P.O.	uires that th n signed by uld be detac	þ	Part II. Other significant conditions contribu	iting to death but not resu	ulting in the u	underlying cause giv	ven in Part I.	23e. Did tot	1/	te to the cause of death?			
of Vital Records,	sician: The law require certificate has been si irector, page 2 should	Completed				_		24a. Was a autops perform	med? prio	e autopsy findings available r to completion of cause of th? Yes 2 \(\sum \text{No} \)			
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n of V	ding Phy. h. After this funeral d	cate: To		1 ☐ Inpatient 2 ☐ 8a. Date of injury (Month, Day, Year)	28b. Time o injury	28c. Injury work			ow injury occurred	эреспуу			
Division	I or Attending F after death. Director: After d in by the funer	Certificate:	a Could not be	Be. Place of Injury - At ho building, etc. (Specify,	me, farm, str	eet, factory, office		28f. Location (St City or Town		r Rural Route Number,			
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical	29a. Certifier 1 Certifying Physician: (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	To the best of my knowled the basis of examination ctitioner: To the best of m	and/or inves	tigation, in my opinio	on, death occurred a	t the time, date an	nd place, and due to	the cause(s) and manner stated.			
	withir comp	<	29b. Signature and title of certifier	nux	\mathcal{C}	29c. License			29d. Date signed (A				
	4		30. Name and address of person who complete the same and address of person who complete the same and the same	40900 Me	ve hou	its lone	Suite 2	05/or	nardt	20650 OWN MD			
	Sta Registr		31. Date filed (Month, Day, Year) 6 2012	32. Registrar's Signat	ure A. A	backet.	5-01/00						

12-07290 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Pettis State of Maryland / Department of Health and Mental Hygiene 33278 2012 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day Year September 26, 2012 **Medical Examiner** 1336 hrs hristopher 4a, Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Crain Highway at Faulkner Road Bel Alton Charles 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6 Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) <u>le nnes see</u> Hours Director 1 X M 2 F 212-78-9438 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maculand Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9609 Oriole 20611 Funeral 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 1 X Yes tant: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner mi 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2 X No specify: Black 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Towin and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname James ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Oriole Alton 20611 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State timore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Jo Jo MI Donation 5 Other Specify -12-12 leterns 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MD 20668 -men tome 23a. Part I. Enter the disease, or complications that caused e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be executed g attending physician or use as the burial -UNPENDED **AMENDED** Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Þ 1 Yes 2 No 3 Probably 4 Unknown pleted After this certificate has been si funeral director, page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Comi Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26. Place of Death (Check only one) Be Other₄ Hospital: 1 Inpatient ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Sep 26, 2012 Pedestrian struck by auto 1 Natural 1336 hrs Pending 1 Yes 2 V No the 2 🗸 Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Crain Highway at Faulkner Road, Bel Alton, MD determined (Specify) Major Road / Highway 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. Signature and title of certifier 29b. 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

ORIGINAL

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

OCME

Patricia Aronica-Pollak MD.

31. Date filed (Month,

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

September 27, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PAPAGIAMMAKIS Month 09 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Manor Care Potomac Potomac . Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 01/23/1924 Director 577-68-3297 88 Russia Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City. Town or Location the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Bethesda Montgomery 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be n permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be once. Funeral 5500 Pembroke Terrace USA 20817 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 21 No Specify. Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Clothing Store / Elementary/Seconday (0-12) Seamstress Fashion Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Stefanos Gaginis Martha Visilynskaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Gag inis / Executor <u>5500 Pembroke Terrace Bethesda. MD 20817</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of 9/27/12 Silver Spring, MD Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 20016 M00063 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Odvanced Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Failure Sequentially list conditions, Examine cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director; After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred iniury 11 Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 inBy 00057458 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pinky Singh, MD 8218 Wisconsin Ave Suite 305 Bethesda, MD 20814

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09/23 2012 2012 3:46 рм Louise Beatrice Perrier Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min. (Month, Day, Year) 7 / 19 / 1927 Director 85 579-08-6285 1 M 2 XF Jamaica Usual Residence of Decedent or then "naturel", or Items 23a or 28e-f show the Medical Evancies must be notified at filed within 72 hours after death with the Maryland al Hygiene. other then "naturel", or Items 23a or 28e-f show 10c. City. Town or Location 10d. Inside City Limits Director DC Washington, DC 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1355 Parkwood Place NW 20010 Jamaica 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ፩ If Yes, Give Year or Dates 1 Yes 2 XNo Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse's Aide Nursing Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Importent: If item 27 is merked othe any Injury or other treumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent Perrier-son 1355 Parkwood Place, NW Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection 9/29/2012 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W.H. Bacon Funeral Home Wandac. Bacon CC0361 3447 14th St., NW Washington, DC 20010 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death SEPTICEMIA Physician/ disease or conditi resulting in death) , Medical Due to (or as a consequence of): Examiner METASTATIC SQUAMONS CELL CARCER OF THE CERVIX Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospital or Attending Physiclen: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit ERICHSION that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☒ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) grafa MD 1346529

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

7325A HAMOVER PARKWAY

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VICTOR ONYEJAKA

31. Date filed (Month, Day, Year)

SEPTEMBER 23, 2012

GREENBELT MARYLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3130 M Medical 4a. Facility Name (if not institution, give street and number) County of Death $P \cdot G$. 4b. City, Town, or Location of Death **Examiner** Fort Washington Fort Washington Medical Center 578-74-2881 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Funeral 6. Sex 1 M 2 □ F If Under 1 Year 9. Birthplace (State or Foreign sept.3, 1936 Director Guyana Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at any injuy or other traumatic event, the Medical Examiner must be notified at 10a. State Md . 10h. County 10c. City, Town or Location 10d. Inside City Limits Director P.G. Fort Washington 1 Yes 2 □ No 10g. Citizen of What Country? 13200 Lenfant Dr. Funeral 20744 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Financial Manager World Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Adolphus E. Phillips Edna Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Marva E. Phillips 13200 Lenfant Dr. Fort Washington, Md. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2012 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremat.Oct.2, Wash.,D.C. CC031 Robinson Funeral Home 1313 6th Stonw1 21. Signature of Funeral Service Licenses 23a. Pard. Enter the disease, or complications that caused the shock, or heart failure. List only one cause or ach line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) OMA CECUM Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -tran: resulting in death) Last physician a sthe burial-Physician/Medical that the death certificate be Box 68760 as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No the 1 ☐ res ∠ ∟ 9 ☐ Unknown Linknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has perform Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 2 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer X Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) SM 30. Name and address of p who completed cause of death (Item 23a) (Type, Print) Elias Debbas Ď 31. Date filed (Mon State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #* PER FhG932 10/19/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ М KING PETERSON 23 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL **LANHAM** PRINCE GEORGE'S 8. Date of Birth

(Month, Day, Year) Social Security Number if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Davs Hours Min. **Director** 126-03-6910 1 X M 2 - F 97 13, 1915 **GEORGIA** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 □ No PRINCE GEORGE'S LANHAM ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a 9885 GREENBELT ROAD 20706 USA "natural", or items Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces 0 Black, White, etc. 1 Never Married 2 Married by 2 X No Yes 1 Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Specify: Completed Year or Dates BLACK item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) GOVERNMENT 2+POLITICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SAMUEL **PETERSON** AURILLA COLLIER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i MICHELLE WADE/GRANDDAUGHTER 8828 EAST FORT FOOTE TERR. FORT WASHINGTON, MD20744 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 XBurial 2 Cremation 3 Removal from State FOREST LAWN CEMETERY 09-27-2012 BUFFALO, NEW YORK 4 Donation 5 Other (Specify) 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME, 21. Signature of Funeral Service Licenses Naphney 7474 LANDOVER RD. HYATTSVILLE, MD 20785 N. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions ASPIRATION n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Dav Pregnant at time of death 2 No ed by the a 9 Unknown signed to ath but not resulting in the Industrying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTIA 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? To the Hospital or Attending Physician: The law autopsy fter this certificate has performe Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita Other: မ 1 🔲 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending n 24 hours after deam.
The Funeral Director: "If 1 Yes 2 No Accident Investigation M 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

75m State

the

within To the

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 06-2011 (Check

29b. Signature

only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year

AH, MD.9470 Annapolised.,

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date sign

Suite 306, Lanham, mi). 20106

3 Certifying Nurse Practitione: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗅 State Registrar Amend #10a, 10b, 10c, 10 ertificate of Perth JM 10/1%2012 . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09/22/2012 7:35 A Iva M. Pannell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9101 Natahala PL Clinton Prince Georges 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. Director 1 🗆 M 2 🔀 F 232-44-1,934 83 10/05/1928 WVА Usual Residence of Deced show 10a. State DC MD at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh must be notified a Prince Georges -Clinton-Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral ington Street, 20735 20032 **AZU** Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ò ģ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: Black "natural" 3 X Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Joseph J. Watkins Gladvs E. Holcomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 9117 Ft. Foote Rd., Ft. Washington, MD 20744 <u>Cynthia P. Covington / daughter</u> item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 9 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Department of Important II any injury or 10/22/2012 Arlington, VA 4 Dona on 5 Other (Specify) Arlington Nat'l Cem-22. Name and Address of Facility Strickland Funeral Services Signal Funeral Savice Licen 6500 Allentown Rd., Camp Springs, MD 20748 23a. Pan-1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 4 months disease or condition resulting in death) Recurrent Pneumonia Medical Due to (or as a consequence of) Examiner 4 years Lymphoma equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 the IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Pregnant at time of death Month Year Day 1 ☐ Yes 2 🔀 No 9 ☐ Unknown the g 🗌 Unknown P.O. | ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Thrombocytopenia, Diabetes Mellitus 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Hypertension, Hyperlipidemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) daughter's examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) house _ 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 🛮 Natural 5 Pending iniury within 24 hours after death

To the Funeral Director: A
completely filled in by the t Accident
Suicide Investigation 2 No 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and t 29d. Date sigged (Month, Day, Year) M10184 20 Jn death (Item 23a) (Type, Print) MST, STE &10, WASHINGTON, DC 20037 30. Name and address of MEDINGE

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 25, 2012 3:32 Physician/ CATHERINE VIRGINIA ROE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** QUEEN ANNE'S GRASONVILLE 210 EVANS AVENUE 5. Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours **Director** 214-80-2213 1 M 2 X F Yrs. MARYLAND 01/08/1939 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No **GRASONVILLE** QUEEN ANNE'S MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 210 EVANS AVENUE 21638 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. OWN HOME HOMEMAKER and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 WILLIAM RICHARD ROE MAMIE ELIZABETH THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. e 1 and 2 s of Health a 45679 BUCKSHOT WAY, LEXINGTON PARK, MD 20653 SAMUEL P. ROE, JR SON Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) STEVENSVILLE CEMETERY 10/01/2012 STEVENSVILLE, MD Sig ur f Funeral Servi FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit Exami requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ate has been sig page 2 should b 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2 No 25. Was case refer d to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Director: After this in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State e Funeral L 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 2012 PATRICIA BOWYER MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sutreville MD 21617 SuitE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33285 State Registration of the State Registration of the Registration o Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 21, 2012 ROTHBERG Donald 1:49 P. M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death
Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Y 1 **X** M 2 □ F Director 79 June 6, 1933 Boston , MA 28a-f show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at Director 10d. Inside City Limits D.C. Washington, DC 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20008 U.S.A. 3232 Woodley Rd., N.W. 12. Was Decedent Ever in U.S. Armed Forces? A PMY 1 ☑ Yes 2 ☐ No If Yes, Give Korean Wa Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed Specify 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) t of Health and Mental Hygiene.

If item 27 Is marked other than "
or other traumatic event. The Man Elementary/Secondary (0-12) College (1-4 or 5+) Associated Press Journalist Be 18. Mother's Name (First, Middle, Maiden Symame, Frances Finn 17. Father's Name (First, Middle, Last) George M. Rothberg should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 3232 Woodley Rd., NW, Washington, DC 20008 Lynn Rothberg / spouse 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of F
Important: If ite
any injury or ot
once. Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery Sept. 24,2012 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) e and Address of Facility Torchinsky Hebrew Funeral Carroll St., NW, Washington, DC 20012 21. Signature of Fun ral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. ir any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Exami Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial framsi that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Day within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completely filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) |2 1 🗌 Yes 2 🌌 No 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 10 2012 D006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9971 Medica 31. Date filed (Month, Day, Yea State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Adolfo Manuel Rodriguez 2012 September рм 10:52 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) 070-44-2189 Hours Director 1 X M 2 □ F 68 Ian. 1, 1944 Cuba Usual Residence of Decedent ral", or itams 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8202 Roanoke Apt. 20912 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ₺ Yes 2 □ No Specify: Cuban SpecifWhite 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Jose A. Rodriguez Eugenia Quiala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William I. Rodriguez/Son 16107 Oak Hill Road, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of Sept. 28, 20c. Location - City or Town, State Important: If it any Injury or o cemetery, crematory or other place) 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 2012 . Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W. Silver Spring, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE YRS Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLUS 3 WKS Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, paga 2 should be detached for use as the bullar-transit cate has been signed by the attending physician and paga 2 should be detached for use as the burlet-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐XNo 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 K No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 ☒ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 70144 4106 30. Name and address of person who completed cause Mike Murray, MD 1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33287 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 2012 Gertrue G. Rexrode 1:10 A MMedical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 317 Roanoke Ave Mt. Lake Park Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD Funeral 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 01/23/1921 Days Hours **Director** 219-14-6299 1 🗆 M 2 🗶 F 91 Usual Residence of Decedent 10b. County 10a. State 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Garrett Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 317 Roanoke Ave 21550 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Health Care other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ည Clyde Landis Anna Mae Friend 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Carla Hyson / Daughter 4281 Md Highway, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 10/4/2012 Deer Park, MD Deer Park Cemetery Signature of Funeral Service Licens 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myclodenous Medical resulting in death) Due to (or as a constitution of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Ø No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 NO ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🖄 Natural injury 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the basis of my knowledge death occurred at the time, date and due to the cause(s) and manner stated (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0031674 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Dr Bernstein MD 31. Date filed (Month, Day, Year)

State

Registrar

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2:20 A M John Lawrence Snyder 20 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death BALTIMORE OWSON MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, Ye April 3, **Funeral** Hours 150-03-9098 **Director** 1 □XM 2 □ F 93 1919 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Tes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9619 10th Ave. 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give ģ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Truck Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Patrick Snyder Frances Marie Bray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John L. Snyder-son 9619 10th Ave. Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hagerstown, MD Oct.8,2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for se a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0065641 Kernul 20hin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ER DRIVE TOWSON, MD 21204 111) 9+1 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2012 6:50 September Barbara K. Stathis Medical 4c. County of Death
Montgomery 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Rockville Shady Grove Adventist Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days (Month, Day, Year) 579-26-7051 Director 1 M 2 X F 86 Jan. 18. 1926 Washington, DC 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No MD Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 20877 415 Russell Avenue, Apt. 419 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black White etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 Married δ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 AWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) District of Columbia Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools Principal 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) Mary Virginia Skippon 17. Father's Name (First, Middle, Last) Harry W. Klotz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5206 Drake Terrace, Rockville, MD 20853 Andrea S. Krupinski/Daughter Date 26, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Fort Lincoln Sept. 2012 1 X Burial 2 Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Cemeters . Signature of Funeral Service Licenses 22 Name and Address of Facility rancis J. Collins Funeral Home Inc. 500 University Blvd. W., silver Spring, MD 20901 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracranial Hemorrhage, non-traumatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, Due to (or as a consequence of) Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this retrificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit nding physician and use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Day Month Pregnant at time of death 5 Other (specify) 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed THE/PL 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 🛣 No 1 Tyes 2 🗆 No .n. r: After this lerun. r-aral director, pr 26. Place of Death (Check only one) Be 25 Was case referred to medica examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 K Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ZD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

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32. Registrar's Signature

Yana

31. Date filed (Month, Day, Year)
SEP 2 5 2012

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DHMH 17 Rev 06-2011

State

Registrar

SEP 25

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records.

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 27, Michael Orlando Spicely Sept 3:36 рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 13316 Queenstown Lane GERMANTOWN Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 229-11-3156 Director 1 ፟ M 2 □ F 39 Yrs. Dec. 5, 1972 VA Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene.

ant: If item 27 is marked other than "naturel", or items 23e or 28a-f show ury or other traumetic event, the Medical Evanther must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13316 Queenstown Lane 20874 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Force Black, White, etc. á 1 Never Married 2 KM Married 1 ☐ Yes 2 🖾 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: **Black** If Yes Give Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Senior Consultant Federal Government 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Preston Howard Spicely Milli N. Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sukriti Sharma Spicely/Wife 13316 Queenstown Lane, Germantown, MD 20874 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or otl 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 🙀 Removal from State cemetery, crematory or other place) Oct. 2, Mt. Poole Baptist Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Ford, VA 21. Snature of Juneral Service Usensee Francers Addres Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Pancreatic Cancer vrs. Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial tages. Exam resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 ☑ No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 🛭 Residence 6 🗆 Other (Specify) 1 🗌 Yes 2XXNo မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 □ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of entifier 20 D73109 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Shannon O'Connor, MD

01

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9707 Medical Center Drive, #300, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT. 28^{Day} 20^Y12 JANE HENRIETTA ROGERS SMITH 1:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY ROCKVILLE NURSING HOME ROCKVILLE If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Days Min (Month, Day, Year) Director 558-14-1338 1 🗆 M 2 🛭 F 93 APRIL 23,1919 CALIFORNIA Usual Residence of Decedent within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No MD MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** DAVID CT. 20904 1 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, <u>ک</u> 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: Completed 3 Widowed 4 Divorced oe filed wn... Mental Hygiene. ''ed other than "nat... ''t. tre Medical Ey Year or Dates WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SCHOOL Elementary/Secondary (0-12) College (1-4 or 5+) 5+ **TEACHER** MONTGOMERY CO. PUBLIC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be JOHN RICHARD ROGERS POTTOL MARY PEARL it. Page 1 and 2 shours out of Health and Mr. m 27 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID CT., SILVER SPRING, MD. 20904 RALPH SMITH/HUSBAND В. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Coremation 3 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 9-28-2012 RIVERDALE, MD. . Signature of Funeral Service Licensee 22 Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CEREBROVASCULAR ACCIDENT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions. Examine ary, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Cause (Disease or injury **SEPTICEMIA** and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physiclan/Medical ACUTE RENAL FAILURE Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed ; page 2 should be de þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 XN To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner i Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 2 X No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident Investigation 3 D Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this operation, actions of the cause (s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Nosoph swom45 D0047330 SEPT. 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 50 W. EDMONSTON DR. SUITE 207, ROCKVILLE, MD.20852

M.D.

THOMAS V. JOSEPH,

0 1 2012

31. Date filed (Month, Day, Year)

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ()9 Jackie Lee Simmons 2012 РМ 2:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1011 John Drive Oakland Garrett Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)

WV Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Days (Month, Day, Year) 10/02/1938 Min. Director 233-62-3158 1 M M 2 D F 73 Usual Residence of Decedent or 28a-f shov 10b. County 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Oakland Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1011 John Drive 21550 USA 12. Was Decedent Ever in U.S. Armed Forces?1

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Airline Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Department of Health and Ments Important: If item 27 is marked any injury or any Harry Simmons Mary Bonner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 John Drive, Oakland, MD 21550 Carolyn Simmons / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/4/2012 Kingwood, WV Sunset Memorial Gardens Crematory Signature of Funeral Service L 22 Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition San Medical resulting in death) or as a consequence of: Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown Division of Vital Records, P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ ate has been signing page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate 1 ☐ Yes 2 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 124 hours after death, e Funeral Director: Af letely filled in by the fu death. Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of cortif 29d. Date signed (Month, Day, Year) DI H26154 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller 69 Wolf Acers Drive Oakland, MD 21550 31. Date filed (Month, Day, Year) **OCT - 4** 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Ethel Rae Snyder 2012 3:20 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 618 E Oak St Oakland Garrett Social Security Number Birthplace (State or Foreign Country)
 MD Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/05/1918 Days Months Hours Min. Director 1 M 2 M F 218-07-4629 94 Usual Residence of Deceden 28a-f show ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 618 E Oak St 21550 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. \$ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examination or other traumatic event, the Medical Examinations or other traumatic events or other events or other traumatic event Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 ₩Widowed 4 □ Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home å 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Little Charles R. Welling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1966 Walton Wood Circle, Tucker, GA 30084 Barbara Beeson / Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) 10/5/2012 Oakland, MD Garrett County Memorial Gardens 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) g 🗌 Unknown ate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Completed | 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funerel Director: After thi etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 2 H26154 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P. Daniel Miller 69 Wolf Acres Drive Oakland, MD 21550

State Registrar 31. Date filed (Month, Day Year) 4 2012

Kegistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	State of Maryland /	Department of F			ene g. No. 2012	33295					
	Physicia Medi		1. Decedent's Name (First, Middle, Last) RICHARD SCIDE	2			2. Date of Death Month		3. Time of Death					
	Examir		4a. Facility Name (if not institution, give stre WM. Regional Medica		4b. City, Town, or Cumber	Location of Death		4c. County of Death Allegany (
	Funeral Director		5. Social Security Number 233-44-7485 Usual Residence of Decedent	7. Age (In yrs. last b)	irthday) If Under 1 Year Months Days Yrs.		8. Date of Birth 11/25/19	9. Birth Coul. 28 West	place (State or Foreign of Virginia					
	Aaryland 8a-f show tified at	rector	10a. State 10b. County Garrett		wn or Location anton				10d. Inside City Limits 1 Yes 2 X No					
	s 23a or 2 s ust be no	Funeral Director	10e. Street and Number 372 Brant Road	l	10f. Zip Code 2156	1		nited State						
9600	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	Specify:	ify Yes or No- ican, etc.)	14. Race - Ameri Black, White, Specify: Wh						
Maryland 21215-0036	within 72 he giene. er than "na er the Medic	Completed by	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		ia. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired) Glass Cutter	ation uring most of working	9	6b. Kind of Business/Ir						
yland	uld be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Ray Slider			18. Mother's Name (Theln	First, Middle, Ma na Derh							
e, Mar	and 2 shou Health and Pm 27 is m		19a. Informant's Name/Relationship (Type, Pearl Slider/ wife	3	9b. Mailing Address (Street a 372 Brant Road	nd Number or Rural I d, Swanton	n, Maryl	and 21561						
Baltimore,	it. Page 1 artment of the rtant: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State Laure	of Disposition (Name of ery, crematory or other place L HIII Cemete		/2012 E	oc. Location - City or T						
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	Good		St, Weste	ernport,	ral Home Maryland	21562					
	Ph _y sician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)											
	Examiner	er	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):											
93	ate be executed bhysician and the burial-transit	dical Examiner	cause. Enter Underlying	RENAL FAILU Due to (or as a consequence										
092	cate be ex physician s the buris	edical	d	LOW CARPIAC	OUTPUT									
	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnancy 1 Live Birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		/		23d. Date of deliv Month	ery Day Year					
ds, P.O.	quires that the en signed by the	by	Part II. Other significant conditions contrib	outing to death but not resulting	in the underlying cause give	en in Part I.		cco use contribute to t	1					
Division of Vital Records,	The law ate has page 2	Completed					24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of					
/ital	sician certifi lirecto	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	pital:	Otho	ce of Death (Check o			-					
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ivision	To the Hospital or Attending Physician: "In thin 24 hours after death and the Funeral Director: After this certifical completely filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, fi building, etc. (Specify)		res 2 □ No 28	Sf. Location (Stree City or Town, S	et and Number or Rura State)	Route Number,					
	ne Hospita n 24 hours ne Funeral pletely filled	Medical	(Check 2 L. Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ actitioner: To the best of my kno	or investigation, in my opinior	 death occurred at th 	e time, date and r	place, and due to the ca	use(s) and manner stated					
	To the vithing the complete of		29b. Signature and title of certifier Motize, M.		29c. License			d. Date signed (Month,	Day, Year)					
		1	30. Name and address of person who comp Dr. Charles Moore,	leted cause of death (Item 23a) 12500 Willowbr	(Type, Print)	erland, MD	21502							
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 2012	32. Registrar's Signature	back			· 						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🥎 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ΑM Ardis Fern Simon September 26, 2012 9:20 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Garrett Goodwill Mennonite Home Grantsville Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 9, 1920 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Washington **Director** 531-28-3627 92 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No AZ Kingman Mohave 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 86409 USA 2330 E. Devlin St. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Daugherty Bessie Steele 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $P.O.\ Box\ 68$, McHenry, MD 21541P.O. Box 68, McHenry, MD Judy K. Prather/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 2012 Davidsville, PA Country Side Crematory Sept. 27, . Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a cor **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 signed by the attending p IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death Year g Unknown 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe death? certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No After this of funeral din ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print lace an mag any gistrar's Signature State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	For State Registrar		State of M	aryıan		ertificate of	Health and I Death	vientai Hy	/giene Reg. No	201	2 3	329
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Funeral		5. Social Security No		7. Ag		ast birthday		If Under 24 Hrs.	8. Date of Bi	rth			e or Foreign
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Physician/ Medical				e cause on each line DISSEM	ninat	ed (ing, such as cardiac	or respiratory a	rrest,		Approxim Interval B Onset an	Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 D 9 ☐ Unknown	months?	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	☐ Ectopic pregnar	ncy			23d. Date of de Month	livery	Year
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the Hosp thin 24 hou the Fune mpleted fi	Medical	(Check 2 only one) 3	Certifying Physic Medical Examina Certifying Nurse	er: On the basis of e	xamination	n and/or inve	estigation, in my opir e, death occurred at t	nion, death occurred a the time, date and pla	at the time, date	and place he cause(e, and due to the s) and manner as	cause(s) and r stated.	manner stated
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rom			ess of person who do W. C. MILLI		eath (Item	23a) (Type		ER DRIVE,	BETHES	DA, I	MARYLAN]	D 2089:	2
Stat	te	31. Date filed (Monti		32 Registra	ar's Signa	ture	ake	,	-	,			

DHMH 17 Rev 7/2009

SEP 2 8 2012 Change p. Again

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Camille Josephine Sansalone 3:05 Рм September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Home Prince George's Hyattsville 5. Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗌 M 2 🖾 F Months Hours Min. 577-32-6582 84 **Director** October Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 X Yes 2 No Ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3372 Chiswick Court, #2B 20906 the Medical Examiner must USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural", Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Malden Surname) ည James Arnone Rosina Tucci permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michael D. Sansalone, Sr. / Husband 3372 Chiswick Court, #2B, Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery 10/1/2012 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Darrel. Rty Rogers Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ementio disease or condition In Known Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 Thino
9 ☐ Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? ρ failure Division of Vital Records, 2 No 3 Probably 4 Unknown Completed page 2 should been 144 pertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ☐ Yes 2☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 M Nursing Home 5 A Residence 6 A Other (Specify) 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 5 Pending work?
1 Yes 2 No 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie word ZJM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main Streit, Laurel, MD 20707 CHOWDIAURY NURUL

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Day 9, ANNSANFORD 2012 1:45A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 4 Austin Court College Park Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Dec. 14, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 220-70-6387 1 □ M 2 🗓 F Ye1957 54 Horrand Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10c. City, Town or Location 10d. Inside City Limits Director Prince George's College Park Maryland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Austin Court 20740 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If teen 27 is marked other than "natural", any injury or other traumatic name. If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Administrative Assistant private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frederick Meade Ruth Esbury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, David R. Sanford -husband 4 Austin Court College Park, Maryland 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 10/6/2012 20c. Location - City or Town, State 1 🗌 Burial 2 💢 Cremation 3 🗀 Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses Bonald V. Borgwardt Funeral Home, PA Wonald 413 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 9 Months Physician/ Diffuse Large B Cell Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) 1 Live Birth 2 Fetal deal
4 Pregnant at time of death
9 Unknown Ectopic pregnancy in the past 12 months? Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural n 24 hours after deam...he Funeral Director: Aft 5 Pending work 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 2, 2012 D63828

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

1 6 2012

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Dongmei Wang, M.D. 9715 Medical Center Drive, #435 Rockville, Maryland 20850

12-07390 Anthony Trela, III Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 33300

		1- For State Registrar				Certific	ate of	Death			R	eg. No.		, , ,		
Physici		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Yes										M. Sala		3. Time of [)eath	
edical Exam	iner	Anthon	v Trela	a III							Septembe	er 29, ∶	Year 2012		2350 h	irs
		4a. Facility Name (if not	institution, giv	e street and n	umber)		4	b. City, Town, o	or Location of	of Death			. County of	f Death		
		12600 Blk Indep	pendence	Road				Clear Spri	ng			V	Vashingt	ton		
Funeral		5. Social Security Number	er 6. S	ex	7. Age (In yrs. last bi	thday)	If Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Bi	rth (MM/I				e or
Director		143-62-6743	1 1	M 2 F		52	Yrs.	Months Da	ys Hours	Min.	04/04	/106	50 l	Foreign Cou	n untry) NJ	г
		Usual Residence of Dec		J = L	-	-	113.				04/04	1130	,0		1VC	,
fu			County		10	Oc. City, Town	or Location	on							10d. Inside	City Limits
- A		MD Wa	achina	ton		Cloor	Cori	na							1 Yes	2 X No
Maryland 28a-f show datonce.	햦	10e. Street and Number	ashing			Clear	Spri	10f. Zip Code				0- 0:::-		1 2		
te Mar or 28,	Director										['	ug. Citiz	zen of Wha	it Coun	itry?	
ith the Maryland 23a or 28a-f sho notified at once.	0	13067 Inc	depende					2172	22				USA			
h wii	Funeral	11. Marital Status 1 Never Married	0 🗆	12. Was Dec		ver in U.S.		Decedent of H)-	14. Race - White,		can Indian, E	llack,
or it	ä		_	1 Yes	2 X	No		o, opeciny educe	an, moxican	i, i dono i	roan, etc.)		vviiite,			
after iner,	by	3 X Widowed 4		If Yes, Give Yes or Dates:			1	Yes 2 X N	o specify:				Specify:	Wh	ite	
5-0036 led within 72 hours after Hygiene. I other than "natural"; the Medical Examine.	P	15. Decedent's Educati		nly highest gra	de compl	eted) 16a.		s Usual Occup st of working lif				16b. K	and of Busi	iness/Ir	ndustry	
336 thin 72 le. than "1 edical E	Completed	Elementary/Secondary	y (0-12)	College (1-4 or 5+)		•	-	5. DO NOT	ase retire	۵,					
withir iene.	Ē	12 th					Elect	rician				Con	merc	ial	Baker	:
Figgi		17. Father's Name (First,	, Middle, Last)					18.Mother	's Name (F	First, Middle,	Maiden (Surname)			
2121; wild be fil Mental F marked c event, i	Be	Anthony (John T	rela, J	r.						arrie					
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. In 27 is marked other than numatic event, the Medical	မှ	19a, Informant's Name/R	Relationship (1	ype, Print)				Address (Stre								
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment offer letten and hould be filed within 72 hours after death and house the marked ofter than "natural", or items 23a or 28a-f the or other traumatic event, the Medical Examiner must be notified at once		Michele H.		/ Sist	er		<u> 13067</u>	Indepe	endenc	ce Ro	ad Cle	ar S	prin;	g, l	MD 217	′22
F. Hea		20a. Method of Disposition 1 Burial 2 X Ci		☐ Domovel fr	om Ctoto	20b. Place crema	of Disposit	ion (Name of co er place)	emetery,]	Date	20c. L	.ocation - 0	Dity or 1	Town, State	
MOFE Pages 1 tent of H tent: If i		4 Donation 5		_	OIII State			rematori	1.Tm	10/05	/2012	Smi	ithsb	11120	MD	
Baltimore, permit. Pages 1 an Department of Hea Important: If itel		21. Signature of Funeral				Juliuk	22. Na	arme and Addres	ss of Facility	Y Cox	ald N.					Llomo
Balt permit. Depart		13.5	12×							GET	Hager	Stov	m. M	$D^{\mathbf{r}} \mathbf{u}$	1740	поше
Physician		23a. Part I. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear													ate Interval	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries														Onset and eath
Examiner		or condition resulting in		Due to (or as a		uence of):										
		Sequentially list condition	ns b.													
	힏	if any, leading to immedi cause. Enter Underlying	ate	Due to (or as a	consequ	uence of):										
	Examiner	(Disease or injury that in	itiated C.	Due to (or as a	CODSAGI	ience of):										
ansit		events resulting in death	ı) Last	240 10 (01 40 0	, oo looqe	301100 017.										
ficate be executed gphysician and transit	/Medical	UNPENDED		AMENDED						-		-				
760, ficate be g physici the buri	Jed	IF FEMALE:		23c Hyas	outcome	of pregnancy						224	Data of d	alivani		
87 tifica ng ph	2	23b. Was decedent pregn	ant in the	1 Live b		or programcy		al death 3	Ectopic	c pregnanc	y		. Date of d Month	•	ay	Year
x 6 h cer tendi	<u>:</u>	past 12 months?		4 Pregr		ne of death		er (Specify)							,	
Records, P.O. Box 68: The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it.	Physician	1 Yes 2 No 9	Unknown	9 Olikii												
Vital Records, P.O. B bysician: The law requires that the d this certificate has been signed by the I director, page 2 should be detached		Part II. Other significant	t conditions	contributing to	death b	ut not resultir	g in the un	derlying cause	given in Pa	art I.	23e. Did to	bacco u	se contrib	ute to th	he cause of	death?
res th	d by										1 Yes	2 🗸	No 3	Proba	ably 4 🔲 l	Jnknown
rds requi	Completed										24a. Was				opsy finding	
CO law has	줱				_						autop perfo	sy rmed?		ior to co ath?	mpletion of	cause of
The	ខ										1 Yes	2 No	1 1	✓ Yes	2	No
certi	B	25. Was case referred to examiner?		lospital:					e of Death (
Z isy is a latin state of the la	ဥ		No j	- '	Inpatient		utpatient			, ,			nce 6 🗹		Scene	
Division of Vital Records, tal or Attending Physician: The law requirers after detector: After this certificate has been sited in by the funeral director, page 2 should t		27. Manner of Death 1 Natural		28a. Date FOUND	of Injury Day,Year	28b.	Time of Inj JND:	. 1	ury at Work	יחו	8d. Describe I river auto			1		
sion tten death ctor:	ä	2 Accident	Pending Investigati				9 hrs	1 1	Yes 2	No						
Or A Dire	ij	3 Suicide 6		De				, factory, office	building, etc	c. 28	8f, Location (\$ or Town, S		d Number	or Rura	al Route Nu	mber, City
ipital Ours	Certification:	4 Homicide	determine	(Specify)	Majo	r Road / H	ighway			12	600 blk Ind	eperide	nce Road	d, Clea	ar Spring, N	<i>I</i> Id
e Hoo 124 h e Fur								ed at the time, o								
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical			On the basis and manner s	of examin tated.	nation and/or	investigatio	on, in my opinio	n, death occ	curred at th	he time, date	and plac	e, and due	e to the	cause(s)	
	Σ	29b. Signature and title of	of certifier					29c. Licen	se number			29d. D	ate signed	(Mont	th, Day, Year)
A		(met) <						0.0	.M.E.			Sept	tember 3	30, 20	12	
DO		30. Name and address of	person who	completed caus	se of dea	th (Item 23a)										
U		Ana Rubio M.D.	, Ph. D.	Assistant I	Medica	I Examine	r 900 \	N. Baltimor	e Street,	Baltimo	ore, MD 21	223				
	ate	31. Date filed (Month, Da	Yeark a	G 7 4		Signature	Ka	P. A.								
Regist	rar	Մ	1 414 0	gie a	10050 A 174	Best Alle		September 1								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9/20/22012 Physician/ LEONILDA ZIZZI TRAETTA Year :25 p Medical . Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death
Montgomery Village Examiner 4c. County of Death 19301 Watkins Mill Road Montgomery Social Security Numbe If Under 24 Hrs. 7. Age (In vrs. last birthday If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 93 085-03-1647 1 M 2 F Month, Day, Ye Director Italÿ Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Village 1 Yes 2 No Montgomery ö 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funera 19301 Watkins Mill 20886 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medis
once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonardo Zizzi Madeline Mastromarini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4420 Ridge Street, Chevy Chase, MD 20815 Madeline Folkes/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/24/2012 Hanover, MD 4 Donation 5 Other (Specify) remation Center 22. Name and Address of Facility Snowden Funeral Home Funeral Service Insee 246 N. Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Failure to Thrive ₽nysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Advanced Dementia Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 XNo 2 No 25. Was case referred to medica examiner? funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐XNo Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 XNatural iniury 5 Pending after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ertifier 29c. License number 29d. Date signed (Month. Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who comp

31. Date filed (Month, Day, Year)

12-07146 Cody Tobias Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 33302

		1- For State Certificate of Death	Re	g. No.	
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	Date of Death Month	Dav Year	3. Time of Death
Medical Examir		Cody Aaron Tobias	September	r 22, 2012	0527 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Mt. Hermon Rd Salisbury	1	4c. County of Death Wicomico	
Funeral	4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8 Date of Birti	h(MM/DD/YYYY) 9. Bird	holace (State or
Funeral Director		Months Days Hours Min	-	Foreig	
	ŀ	Usual Residence of Decedent	10 31	1331	110
any	ŀ	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
≜ .π	_	MD Worcester Ocean Pines			1 Yes 2 No
Maryland 28a-f show i at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?
the M		2 Sandridge Road 21811		USA	1
5-0036 led within 72 hours after death with the Maryland Hygiene. other than "matural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Specific Specif		14. Race - Ameri White, etc.	can Indian, Black,
death or ite	إج	1 Yes 2 No	rtican, cic.)	Wh	iite
s after ral",	à	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: or Dates:		Specify:	
hour natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of oduring most of working life. DO NOT use retired to the control of the		16b. Kind of Business/I	ndustry
36 bin 72 than	ple	12		Distribu	tion
5-00 ed with tygien other	녌	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, M		1011
21215 wld be file Mental H marked o	Be	Curtis Wayne Tobias Diane	Miche	lle Mille	er
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatte event, the Medica	ျ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Route Numi	ber, City or Town, State	Zip Code)
MO 2 st alth an alth an arms		Curtis Tobias-Father 2 Sandridge Road,			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: Witem 37 is marked other than "natural", or items 23a or 28a-1 sh injury or other traumatic event, the Medical Examiner must be notified at once		20a. Method of Disposition 1 Burial 2 Ferenation 3 Removal from State First State Crem.	Date	20c. Location - City or	′ ′
Page ment connections		4 Donation 5 Other Specify:	28-2012	Millsbor	O,DE
Balt Depart Import		21. Surrour of Furrial Service Licensee 22. Name and Address of Facility	e Burb	age Funer	al Home
		23a. Part I. Enter the disease, or complications that capsed the death. Do not enter the mode of dying, such as cardiac or	Berlin	age.Funer	Approximate Interval
Physician		failure. List only one cause on each line.	respiratory arre	st, shock, of fleat	Between Onset and Death
Examiner	- 1	Immediate Cause (Final disease or condition resulting in death) a. Chest Injuries Due to (or as a consequence of):			Deasi
**	- 1	Sequentially list conditions, b			
	힐	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	cuissase or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
xecuted n and - transit		d.			
ਾ ਕਰ	Medical	UNPENDED AMENDED			
760, icate be con physiciar the burial	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	,
Sox 687 Leath certificate at the ast the set t		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnated time of death 5 Other (Specify)	ancy	Month E	ay Year
Box 68 death certif the attending of for use as	Physician	1 Yes 2 No 9 Unknown 9 Unknown			
P.O. B. sthat the degree by the detached is		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that tre after death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detac	d b		1 Yes	2 No 3 Prob	ably 4 Unknown
rds requi	Completed		24a. Was a		topsy findings available ompletion of cause of
eco ne law te has	틹		perform	med? death?	
Vital Rec ysician: The l his certificate h director, page		25. Was case referred to medical 26.Place of Death (Check	only one)		
Vita	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursin	ng Home 5 🗌 F	Residence 6 🗸 Other	; Scene
VISION OF ' or Attending Ph fler death Director: After t in by the funeral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending FOUND: 1 Yes 2 No.		ow injury occurred o involved in collis	ion
ion trendi leath.	atio	1 Natural 5 Pending FOUND: FOUND: 1 Yes 2 No Sep 22, 2012 0515 hrs			
ivision or Atten after death Director:	Certification	28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru ate) d, Salisbury, MD	ral Route Number, City
ion non	8	200 Codifier			
To the How within 24 h To the Fur	edical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To T com	Med	and manner stated. 29b. Signature and title of certifier 29c. License number		29d. Date signed (Moi	
	-	O.C.M.E.		September 23, 2	
_	}	30. Name and address of person who completed cause of death (Item 23a)			
046		Jack Titus MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore	, MD 21223		
St	ate				
Regist		3 C C () () () () () () () () ()			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ September 26, 2012 Dorothy Kathleen Triplett 5:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Goodwill Mennonite Home Grantsville Garrett 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours Min Dec. 26, Year 1912 296-01-2649 **Director** 99 Yrs. Maryland Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Garrett Oakland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 705 Sunshine Drive 21550 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Beautician Beauty Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed f Health and Mental H item 27 is marked ot John Truman O'Brien Mary Brenneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Betty Mattingly/Niece 225 Sunset Lane, Oakland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Country Side Crematory Sept. 27, 2012 Davidsville, PA Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. -Osur P.O. Box 386, Oakland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between Immediate Cause (Final Onset and Death ALZHEIMERS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 -No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

I Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined Medical 29a. Certifier 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital completed filled in by

Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 31. Date filed (Month strar's Signature 28 201

State Registrar

29b. Signature and title of certifier

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

September 26, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death C Month Physician/ Month Pember 24 Year 2012 1 rowell 6:45 A M ranklin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death PRINCE GEORGE'S FUTURE CARE PINEVIEW CLINTON 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min nth, Day, FEB. FLORIDA Yrs Director 1965 251-23-6022 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Funeral Director 1 Yes 2 No MD PRINCE GEORGE'S CLINTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5212 PLATA STREET 20735 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2X No Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify BLACK "natural", Specify: Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2YRS HOME IMPROVEMENT PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FRANKLIN TROWELL, SR. MARY JANE KEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5212 PLATA STREET CLINTON, MD 20735 JENNIFER TROWELL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
WASH. NAT'L CEMETERY 10-01-2012 20a. Method of Disposition 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State SUITLAND, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani ication disease or condition resulting in death) Medical s a consequence of Examiner edestrian Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the contribution of the contribut the attending physician and thed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown sate has been signed by tage 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 N Be To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Hospital Other 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☑ No Natural 5 Pending May 29 2009 3136 A M 2 Accident Investigation 6 Could not be Suicide lace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Columbia, Md street Route Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

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DHMH 17 Rev 7/2009

State

Registrar

29b. Sig

GroU 31. Date filed (Month, Day Year

SEP 2

Pineview

9106

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

FEEE200

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mary	•	artment of H		lental Hy	giene, Rag. No.	/ /	33305
			1. Decedent's Name (First, Middle, La	ıst)				2. Date of Do	eath Day	Year	3. Time of Death
	Physici		JOYCE ANN MCINTOS	H THOMAS				9-18-	-	rear	2118 Рм
	/Medic Examin		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town, or	Location of Death			County of Deat	h
			THE JOHN HOPKINS	HOSPITAL		BALTIMOR	E CITY				
	Funeral				n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth av. Year)	9. Birt	hplace (State or Foreign
	Director		411-82-7658	^{1□ M 2} AF 63	Yrs.	Worting Days	Tiodis Will.	2-1-19	49		TN
	p ,		Usual Residence of Decedent 10a. State 10b. County	10	Dc. City, Town or Lo	cation					10d. Inside City Limits
	anyla eho	2	VA FAIRFA		SPRINGFIE						1 X Yes 2 No
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	Vith I	급	10e. Street and Number	OHDE		10f. Zip Code			- 6	en of What Co	ountry?
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or items 23a or 28a-f ehow event, the Medical Examinar minit be motified at	Funeral Director	8214 SOUTHWATER C		-:-116 123	22153	annie Origin? (Cr	nadu Vas as N	U	S 4. Race - Ame	nican Indian
•	er de	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 XNo	IT IN U.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	0-	Black, Whit	
5	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		Yes 2XNo	Specify:		5	Specify: BL	ACK
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	other ent,	BeC	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle	e, Maiden S	Sumame)	
Ö		To B	GEORGE J.D. LIVI	NGSTON			DAISY N	CHOLSO	N		
2	g p E E	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Numi	ber, City or	Town, State,	Zip Code)
	1 end 2 Health a tem 27 ie		HAROLD THOMAS SR	./HUSBAND	8214	SOUTHWAT	ER COURT.	SPRIN	GFTEL	D. VA	22153
ב ב	tem 2 item 2 other		20a. Method of Disposition		20h Place of Disno	eition /Name of		Date	20c. Loc	ation - City or	Town, State
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baltimore,	permit. Page Department Important: if any injury or once.		21. Signatur of Funeral Service Lice	nree	22	. Name and Addres	s of Facility PO	PE FUNE	RAL H	OMES, 1	P.A.
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) F	Physician		Immediate Cause (Final disease or condition	a SEPSIS							Onset and Death
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20	larylan 28a-f sl	Director		10e. Street and Number		8				10f. Zip Code	-	1	0g. Citizen of Wha	it Count	try?	
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	r Attend re Attend ter death irector: n by the	ficat			vestigation	28e Place	e of Injury	- At home, fa	rm, stree	t, factory, office bu	ilding, etc.			or Rura	al Route Number, City	
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	Division of Vital Records, P.O. Box 68761 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in which fineral director, page 2 should be detached for use as the be	Medical		Critical Crity		On the basis	of examina	_		red at the time, date ion, in my opinion, e						
	To Wil	Me	1	29b. Signature and title of cert	fier	and manner s	tated.			29c. License	number		29d. Date signed	(Mont	h, Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 33307 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 yea Sept.17 2145 Chao Chen Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Numb If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 128-14-2545 Days Hours **Director** China 10720/1914 1 X M 2 🗆 F 97 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Montgomery MD Chevy Chase Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 4403 Elm Street 20815 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Chief Scientist Research permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kien Ching Wang Wei Pie Chuang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Seroun Mei Mei Wang/daugh 4403 Elm Street Chevy Chase, Maryland20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place Holmdel Cemetery 9/21/2012 Holmdel, New Jersey 21. Signatura of uneral Service License PHTLTP D. RIWALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Urinary tract infection Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Inc. rlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ stroke Completed 1 \square Yes 2 \square No 3 \square Probably 4 \swarrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 Yes 2 😾 No 1 Yes 2 🗆 No Division of Vital To the Hospitallor Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 [XNo Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this npletely filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours. To the Funeral 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) address of person who completed $m{c}$ ause of death (Item 23a) (Type, Print) Haaq MD. 8600 Old Georgetown Rd Bethesda, Md 20814 Nàtasha 31. Date filed (Month, Da

DHMH 17 Rev 06-2011

State Registrar

CHAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 23, 2012 Physician/ 3:15 AM Joseph Francis Woods Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Regional Prince George's Hospital Laure If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hours Min. **Director** 187-44-2566 1 XM 2 F 68 1944 March 11, Usual Residence of Decedent Maryland or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2√ No MD P.G Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6001 Ammendale Road 20705 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Black, White, etc. 1 X Never Married 2 ☐ Married Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 XNo 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: and Mental Hygiene. Specify: White 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Joseph F. Woods permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic Dorothy M. Sauer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McErlean, FSC/Religious 6001 Ammendale Road, Beltsville, MD 20705 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sept. De La Salle Cemetery 4 Donation 5 Other (Specify) 2012 Beltsville, 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W. Silver Spring. MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Disease Arterioscleratic Physician/ over disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Fibrillation Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Diabetes Mellitus To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 X No 1 Yes 1 X Inpatient 2 - ER/Outpatient 3 - DOA 유 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 XNatural 5 Pending work? 2 Accident
3 Suicide 2 🗆 No Investigation within 24 hours after death

To the Funeral Director: A

Completely filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the 29b. Signature and title of certifie D 24721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) aurel Bowie Road, Suite 208 Laurel, Syed Sadiq, M.D. 14333 20708 ear) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33309 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER Day 21 2012 DWAYNE WHITELY 5:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 9. Birthplace (State or Foreign Country) ST ANN JAMATCA 8. Date of Birth (Month, Day, Year) 6-28-1988 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified ST. ANN 1 🗆 Yes 🚈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JAMAICA SHELLY ROAD DISTRICT BAMBOO 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner Armed Force ò 1 Never Married 2 Married ò 1 ☐ Yes 2 🔀 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 Tes 2 X No Specify: Completed 3 🗌 Widowed 4 🗌 Divorced Year or Dates ed other than "natur event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) رمالات... مرع is marked other than " er traumatic وهمت Elementary/Seconday (0-12) College (1-4 or 5+) BRICKMASON PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ HYACINTH MEREDITH ANTHONY WHITELY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHELLY RD DISTRICT BAMBOO, ST. ANN, JAMAICA HYACINTH MEREDITH/MOTHER permit. Page 1 and 2. Department of Health Important: If item 27 any injury or other tronce. 20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place CEDAR HILL CEMETERY 9-28-12 4 Donation 5 Other (Specify) SUITLAND, MD 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Licenses 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part Enter the disease, or complications that care ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ APLASTIC BNEMIA Medical resulting in death) Due to (or as a consequence of): Examiner 24 NOHODUZZA PHEUKONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) DISEASO Cause (Disease or linjury that initiated events resulting in death) Last VERSUS Hospital or Attending Physician: The law requires that the death certificate be executed GRAFT HOST use as the burial-tran Due to (or as a consequence of): attending physiciar Physician/Medical ELABOID PNUL Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 1 Yes 2 No 9 Unknown Por Month Day ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. iis certificate has been signed director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 0 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this of completed filled in by the funeral directors.

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29b. Signature and title of certifier

007444 1710

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICAELA IANTORNO

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

State Registrar

3

Medical

31. Date filed (Month, Day, Year) 8 201 32. Registrar's Signature es orten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#5perINF, 9/27/12; BMW: MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month SEPT. Tai Lew Yan Yee аМ 9:00 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 206 Red Tail Court Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-58 1943 Months Days Hours Min (Month, Day, Year) Director 1 □ M 2 X F 94 Yrs 10, 1918 China Usual Residence of Decedent or than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20902 11419 Monterrey Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 A No Specify If Yes Give 3 K Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Hygie I other Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed. Department of Health and Mental H. Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) ၀ Thoms Ams Ng Wah Tue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 206 Red Tail Court, Silver Spring, MD 20905 Donald L. G. Yee/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, MD Signature of Funeral Service Licensee P^{22. Name and Address of Facility} Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Aortic Aneurysm Rupture disease or condition resulting in death) seconds Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) bause (Disease or injury been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: es, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No

l or Attending Physician: The law requires that the death certificate be executed after death. Division of Vital Records, P.O. Box 68760 page 2 this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director.

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Medical Certificate: To

examiner?								
1 ☐ Yes 2 🙀 No	Hospital: 1 lnpatient 2	ER/Outpatient 3 1	OOA Other: 4 Nursing H	ome 5 □.Res	SON'S TESTORNOE sidence 6 State (Specify)			
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No		how injury occurred			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At he building, etc. (Specif)		ry, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Exam	iner: On the basis of examinatio	n and/or investigation, in	my opinion, death occurred a	at the time, date	cause(s) and manner as stated. and place, and due to the cause(s) and manner stated o the cause(s) and manner as stated.			
29b. Signature and the of certifier	la	29	D09834		29d. Date signed (Month, Day, Year) Sept. 21, 2012			

26. Place of Death (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3720 Farragut Ave., Kensington, MD 20895

Barry Rosenbaum, MD 31. Date filed (Month, Day, Year)

2 5 2012

25. Was case referred to medical

32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of M	larylan		artment of <i>tificate of</i>			1ental Hy	giene Z Reg. No.	201	2 3331
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	Funeral		5. Social Security Nur 578-54-54	mber 6. 8		ge (In yrs. Ia	ast birthday)	If Under 1 Year Months Day	r If Und	ler 24 Hrs.	8. Date of B (Month, D	irth	9. Bit	thplace (State or Foreign ountry)
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036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked thygiene, is marked than "natural", or items 23a or 28a-f show is marked than "natural", or items 23a or 28a-f show armatic event, the Medical Examiner must be notified at	þ	1X Never Marrie 3 ☐ Widowed 4		Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	₹ _{No}	1	Yes, specify Cu			Rican, etc.)	- 1	Black, Whit	te, etc.
Maryland 21215-0036	72 hou in "natu Medical	Completed			rade completed)		(Give I	lent's Usual Occ kind of work don O NOT use retire	e during m	ost of worki	ing	16b. Kind	of Business	/Industry
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and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (Fi								e (First, Middle ohnson	e, Maiden Sun	name)	
lary	should be file n and Mental I 7 is marked o raumatic eve		19a, Informant's Nan	ne/Relationship (Type, Print)		1	g Address (Stre	et and Nun	nber or Rura	al Route Numb			
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Baltimore,	0			Cremation 3 5	☐ Removal from State cify)	~ I	emetery, cren t Linc	natory or other p	lace)	9/20	/2012	Brent		
Ball	permit. Page Department Important: I any injury or	1	21. Signature of Fund	eral Service Licer	homps	سسور								ice, Inc. 20012
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% X	ath certi tttendin for use	Physician/M	IF FEMALE: 23b. Was decedent p in the past 12 m	onths?	23c. If yes, outcome 1 Live Birth 4 Pregnant	2 🗌 Feta	aldeath 3 🗆	Ectopic pregnation Other (specify)				230	I. Date of de	elivery Day Year
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Division of Vital Records, P.O. Box 68	uires that n signed uld be de	by	Part II. Other signific		contributing to death	but not res	ulting in the u	nderlying cause	given in Pa	art I.				o the cause of death? Probably 4 X Unknown
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fVit	Physical this ce ral direc	은	1 Yes 2 X	No	Hospital: 1 XInpa 28a. Date of in		ER/Outpatier	II 3 LL DUA		Nursing Ho		sidence 6		cify)
o uc	ath. r: After ne fune	icate	1 X Natural 2 ☐ Accident	5 Pending Investigation	on (Month, D	ay, Year)	injury	W	jury at ork? □ Yes 2	! 🗆 No	28d. Describe	how injury o	curred	
Division	al or Atte s after de il Directo ed in by th	Certificate:	3 Suicide 4 Homicide	6 U Could not determined	28e. Place of Ir	njury - At ho tc. (Specify		eet, factory, offic	e			(Street and N own, State)	umber or R	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2	Medical Exar	nysician: To the best of miner: On the basis of urse Practitioner: To the basis of	examination	n and/or inves	tigation, in my op	inion, death	h occurred a	t the time, date	and place, an	d due to the	cause(s) and manner stated
	To the congression of the congre		29b. Signature and ti	tle of certifier	Jayanti	Potel	m.D.	4.	nse numbe	586	,		igned (Mon	th, Day, Year)
	·		1	ss of person who	completed cause of	death (Item	23a) (Type, F	Print)	-					
j,	Sta	te	31. Date filed (Month	Day, Year)	1 1500 For		ire pa		Lver :	эћтли?	5, FID 2	טזנט.		
	Registr	ar	ı SE	L x 9 50	12 Centru	U B	4 4							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Donna Rae Zwick 5:54 p. 2012 Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Frederick 10656B Baltimore National Pike Myersville 5. Social Security Number Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months March 14,1934 1 □ M 2 🖫 F IIIInois 78 **Director** 321-26-4694 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Frederick Myersville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a ul Hygiene. I other than "natural", or items 23s vent, the Medical Examiner must b 10656B Baltimore National Pike 21773 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. δ 1 Never Married 2 XMarried Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of Donovan Sr. Dagney Johnson Richard Joseph permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Basil Zwick/husband 10656B Baltimore National Pike, Myersville, MD21773 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Remoyal from State 4 Donation 5 Other (Specify) Hagerstown Crematory Oct. 10, 2012 Hagerstown, Maryland 21. Signature meral Sero 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Atherosclerofic Vascular Disease Physician/ diseas or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Cardiomyopath 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Was a autopsy performed page 2 certificate has Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Tes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 🗸 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-9-12 D0058726 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO Myersville 21173 Warren Ventrie Ct. 3000 -D vette 31. Date filed (Mon Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** 30, 2012 21:18 Sept. Freda Belinda Agee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly Prince Georges Prince George's Hospital Center 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M 2🂢 F Days 59 10,1953 Wash., DC Director 578-72-8367 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 No Director MD Prince Georges Landover 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA Funeral 6826 W. Foredt Road 20785 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □ Yes 2 XNo Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounts Technician Federal Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Gladys M. Haskins Caesar A. Agee ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau once. Stephanie Agee/Daughter 6826 W. Forest Road, Landover, MD 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Geo Washington Cem 10/5/12 Hyattsville, MD 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee lot 14th Street, NW, Wash., DC 3821 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has t irector, page 2 sl Hospital or Attending Physician; The performed 1 □ Yes 2 🖾 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) Hospital: di 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCtober 2, 2012 D0061555

State Registrar

DHMH 17 Rev 1/2001

Douglas 0.

MD 3001 Hospital Drive, Cheverly, MD Mayo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20785

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #7&16a Per FH G932 10/24/2012 JH state of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ID DM Joseph Daniel Alston Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore Levindale Nursing 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 XM 2 | F N. Carolina 0372671923 238-26-1679 90 89 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director N/A Baltimore 1X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21215 U.S.A. 3821 Roland View Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces 1 Never Married 2 Married 1 Yes 2 **X**Vo should be filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 X Widowed 4 Divorced Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry a. Decedent's Usual Occupation
(Give kind of work done during most of working

CipathOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Armco Steel 8th Grade Claim Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mattie Alston James Alston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Dwight Thomas Sr. 3821 Roland View Ave., Baltimore, MD (son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State on-site Crematory 10/33/12 Baltimore, MD 4 Donation 5 Other (Specify) 21. Sign tille A lineral Service Lic Forephodes Brown Jr. Funeral Home PA 21217 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Whursing Home 5 - Residence 6 - Other (Specify) Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🗓 定 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year)

OCT 1 7 2012

State Registrar

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		1- For State Registrar		Certificate of	Death		R	eg. No.			
Physici Medical Exam		1. Decedent's Name (First, Middle, L Kaylee Evanda-C		ld			2. Date of Dea Month October 1		3. Time of Death 0715 hrs		
Take.		4a. Facility Name (if not institution, 2003 Ramsay Street	give street and number)	4	b. City, Town, Baltimore	or Location of De	eath	4c. County of Dea	th		
Funeral Director		825 92 2366	Sex 7. Age (In y	yrs. last birthday) Yrs.	Months Da	ays Hours	Hrs. 8. Date of Bir Min. 09/07	Fore	irthplace (State or ign ountry) MD		
and show any nee.	'n	Usual Residence of Decedent 10a. State 10b. County MD		City, Town or Location Baltimore	on				10d. Inside City Limits 1 XXYes 2 No		
vith the Maryland s 23a nr 28a-f show s e notified at nuce.	Director	10e. Street and Number 2003 Ramsay St.			10f. Zip Code 21223		1	0g. Citizen of What Co USA	untry?		
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a ur 28a-f abo matic event, the Medical Examiner must be notified at mee	by Funeral		1 Yes 2 X N ed If Yes, Give Year or Dates:	No 1	s, specify Cub Yes 2 X N	an, Mexican, Pu		White, etc. Whi Specify:			
1036 Athin 72 hours ene. er than "natur Medical Exam	Completed 1	15. Decedent's Education (Specify Elementary/Secondary (0-12) 0	College (1-4 or 5+)	d) 16a, Decedent during mo		oation (Give kind fe. DO NOT use	retired)	16b. Kind of Business	/Industry		
MD 21215-0036 11 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medical	Be	17. Father's Name (First, Middle, La Elwood Arnold	,			Amber	ame (First, Middle, I Wright				
	2	19a. Informant's Name/Relationship Amber Wright / I	Mother	2003 F	Ramsay	St., Bal	ltimore, 1				
Baltimore, N permit. Pages I and 2 Department of Health Important: If item 2 injury ar other traus		20a. Method of Disposition 1	Removal from State	ob. Place of Disposit crematory or oth Mt. Zion (er place) emeter	y 10		20c. Location - City of Baltimore,	MD		
	1	Marken	M014!	52 Bai	ley Fu	neral Ho polis Ro	ome and C	remation Se horpe, MD 2	ervice, PA 21227		
Physician /Medical Examiner		23a. Part I. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b	ce of):							
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Box 6876 death certificat the attending phy	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 V No 9 Unknown	23c. If yes, outcome of p 1 Live birth 4 Pregnant at time of 9 Unknown	2 Feta	al death 3 er (Specify)	Ectopic pre	gnancy	23d, Date of deliver	ry Day Year		
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Cords, law requir has been s	Completed						24a. Was autop perfor 1 V Yes	sy prior to rmed? death?	utopsy findings available completion of cause of		
	Bec	25. Was case referred to medical examiner?	Hospital: 1 Innationt 3			ce of Death (Che					
of Vi ing Physi After this	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of In		Other Nu jury at Work?		Residence 6 Othe	er: Scene		
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Division of Vital To the Hospital or Atteoding Physician: within 24 hours after death, To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	2 Accident Investige 3 Suicide 6 X Could not determine	ot be 28e. Place of Injury -	At home, farm, street		building, etc.	28f. Location (Sor Town, Saltimo)	Street and Number or Ritate) 2003 Rams	ural Route Number, City say St.		
Divis To the Hospital or Al within 24 hours after d To the Funeral Direc	Medical (29a. Certifier (Check only 1 Certifying Physone) 2 Medical Examin	cian: To the best of my know er; On the basis of examination and manner stated.	vledge, death occurre on and/or investigation	ed at the time, on, in my opinio	date and place, a on, death occurre	and due to the caus ed at the time, date	e(s) and manner as sta and place, and due to ti	ted. ne cause(s)		
FSFS	ž	29b. Signature and title of certifier	~			nse number		29d. Date signed (Mo			
		30. Name and address of person wh	o completed cause of death (Item 23a)				30.000 10, 201	- E		
<u> </u>	8 9	Ling Li, MD Assistant	Medical Examiner 9	00 W. Baltimore		iltimore, MD	21223		1		
St Regis		31 Date filed Month, Pays Year)	32. Registrar's Sig	of face	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33316 Certificate of Death 1. Decedent's Name_(First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 9 okia 6'00 AM 2012 Medical Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Unsing & Reh Howard Ellicott City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 New York 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🔀 F Months Yrs February 17,1927 **Director** 093-22-5243 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Howard Jessud Maryland 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a U.S.A. 7747 Sharewood Drive 20794 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married Ş Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ August Fuhres Grace Swan t. Page 1 and 2 should by timent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7944 Dorsey Run Road Jessup, Maryland 20794 Melvin Ouick (Friend) other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Department o Important: If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) 10-12-2012 Columbia, Maryland 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Cardiovaraila Immediate Cause (Final AlteroPclero Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed -trar Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical P.O. Box 68760 attending ph I for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death
Unknown ed by the detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Was an Jas autopsy death? certificate Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 3064 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sahapalhi Read 201-109 Kamesh Back KWE MEK

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3331 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OW 2012 Medical not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death RandallStown Honor 9. Birthplace (State or Foreign Country) UNK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday **Funeral** Director 1 M 2 N 93 Yrs. or 28a-f shov 10a. State 10h Counts 10c. Citv. must be notified at 10d. Inside City Limits Director Baltimore 1 Xes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral should be filed within 72 hours after death with and Mental Hygiene.

is marked other than "natural", or items 23a 451 ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. or i 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 240 Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) UNK 18. Mother's Name (First, Middle, Maiden Surname) / 1016 ဨ permit, Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Coole raver Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 7/2017 15 more 5 Other (Specify) 4 Donation of Fuperal Service Lice 21. Signatu 22. Name and Address of Facility MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) PAVT Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence on Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a the burial-Physician/Medical Box 68760 as ed by the attending a IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown s been signed by the should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy perform death? Yes 2 Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes ျှ 1 Inpatient 2 I ER/Outpatient **从**lursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending work? Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide after determined City or Town, State) within 24 hours a

To the Funeral I Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 037513 16, 2012 30. Name and address of person who ause of death (Item 23a) (Type, Print) MO 100 2613 Mo Registrar's Signatur State Registrar

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		1	For State Registrar	State of	Maryland /		rtment of H tificate of D		d Mental Hy	giene Reg. No.	2012	33318
	ysicia: Medic	_	1. Decedent's Name (First, Middle, La Earle H. Bellew	st)					2. Date of De Month	eath Day	Year 2013	3. Time of Death 5.70 PM
776	xamin	_	4a. Facility Name (if not institution, giv	e street and numbe	r)		4b. City, Town, or	Location of De	ath	4c. 0	County of Dea	th
-				e HOSPI			Rosedo	If Under 24 H	lro o p . (P)		2/+10	
	neral ector		5. Social Security Number 6. 8	Sex 7. IX M 2 □ F	Age (In yrs. last bir	thday) . Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Date)	ay, Year)	Co	thplace (State or Foreign ountry) t Virginia
ъ В	L 6		Usual Residence of Decedent 10a. State 10b. County		90 10c. City, Tow	un or loo	otion		12/00/	1921	wes	10d. Inside City Limits
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with with	ust b	eral	11250 Belair Roa	ad			21087	7		U.S	S.A.	
death	ner m	F	11. Marital Status	12. Was Decede Armed Force		13. W	as Decedent of His Yes, specify Cubar	spanic Origin? , Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	1	4. Race - Ame Black, Whit	
36 after of	xamir xamir	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give Year or Dates	□ No		☐ Yes 2 🛱 No			S		hite
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nd 2	event,	a	17. Father's Name (First, Middle, Last)			<u> </u>	Spr Griedz		Name (First, Middle	, Maiden S	-	
ryla uld be	natic (욘	Allen Boyd Belle						ey Fentre			
Mai 2 short th and	traum	1	19a. Informant's Name/Relationship (Kathy Lynch	**	- 1				Rural Route Number			p Code) 21085
Te, 1 and f Heal	other	ŀ	20a. Method of Disposition		20b. Place	of Dispos	ition (Name of		Date		cation - City or	
Page	II.y or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec				atory or other place n Church		/16/2012	Balt	imore,	Maryland
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Incorporate 18 form 27 is maryland After then "Inchment" or items 228 or 282 formula	any inju		21 Signature of Funeral Service Licer	nsee	2	22.	Name and Address	s of Facility E		sahn 1	Funera , Mary	L Home, P.A. Land 21087
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau	sed the death. Do							Approximate Interval Between
Physi			Immediate Cause (Final disease or condition	Total	Cranio	1 1	temorr	hage				Onset and Death
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68760 certificate be	s the	ledic		d					****			
certificant	. use a	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco		th 3 🗆	Ectopic pregnancy	M		2	3d. Date of de	elivery
Box e death c	hed for	Completed by Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nt at time of death		Other (specify)				Month	Day Year
P.O.	detac	Y P	Part II. Other significant conditions	contributing to deat	h but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute t	o the cause of death?
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Division of Vital Records, all or Attending Physician: The law requires is after death.	n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 28e. Place of	Injury - At home, f etc. (Specify)	farm, stre	et, factory, office			(Street and wn, State)	Number or Ru	ural Route Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funzaria Director After this certificate has been signed by the attending physician and	/ filled i	calc	29a. Certifier 1 Certifying Ph	ysician: To the bes	t of my knowledge	death o	ccurred at the time	, date and plac	ce, and due to the c	cause(s) an	d manner as s	tated.
n 24 h	pletely	Medical	(Check 2 Medical Exar only one) 3 Certifying Nu	niner; On the basis	of examination and	or investi	gation, in my opinio	n, death occun	ed at the time, date	and place,	and due to the	cause(s) and manner stated.
- To the	E 00		29b. Signature and title of certifier				29c. License			29d. Date	signed (Mon	th, Day, Year)
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10	11		30. Name and address of person who					(4 Deall	2 Balt -	550	, 21	227

State Registrar Dr. Daniel Shinners 9000 Franklin Square Drive Baltimore mo 21237
31. Date filed (Month Dayrear) 7 2012 32 Jegistrar's Signatury. January

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Edmond Burke 2012 01:45 AM Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 280 Beach Avenue Pasadena Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Aug. 12 Yel 946 1 □XM 2 □ F Days Country) MD 66 Director 216-44-6436 Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examinar must harmonism and injury or other traumatic event, the Medical Examinar must harmonism and 10a. State 10c. City, Town or Location 10d, Inside City Limits Director 1 Yes 2 XNo Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 280 Beach Avenue 21122 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1964-If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Completed 1967 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Northrop Grumman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas E. Burke Sr. Ethel Warr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela J. Burke (spouse) 280 Beach Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State Oct Date 22 Maryland Veterans Cem 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Crownsville, Maryland 2012 4 Donation 5 Other Sig tive of Funeral Service 22. Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> Part I. Enter the disease, or complication shock, or heart failure. List only one caus tha caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ HABDOMYUSARLOMA disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** MENAL if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) LABETE Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 Division of Vital Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at work? 1
Yes Certificate: 28d. Describe how injury occurred Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide 2 \square No Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 244 MAGOTHY BEKUT ROAD PASADEMA MIDZIG OFTON MPCP HARRES

Registrar

State

32. Registrar's Signature

7 2012

12-07749 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 33320 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar

		Asician/ Development Name (First, Windle, Last) Kaminer Michael Walker Beaty / October 12, 2012									2101 hrs						
									b. City, Town, o	*'					4c. County of Death N/A		
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State 31. Date filed (Month, Day, Year) OCT 1 7 2012 Registrar

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Funeral Director		240-46-		1 □ M 2 🏋 F	ast birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Usual Residence of	Decedent		80				IAPTII 2	1,00	932 15011		
	ctor	10a. State	10b. County		10c. City, Town or Location							10d. Inside City Limits	
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death items ner m		11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S		Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		14. Race - Ame Black, White		
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nding th. : After : funer	Certificate:	1 Natural 2 Accident	5 Pending Investiga	(Month, Da	y, Year)	injury	work						
Atter er dea ector by the	ertifi	3 Suicide 4 Homicide	6 Could no	ot be 280 Place of Ini	ury - At ho	me, farm, stre	eet, factory, office				et and Number or Rural Route Number,		
ital or urs aft ral Dii				10					City or Tow				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Ex	Physician: To the best of aminer: On the basis of a	xamination	and/or invest	tigation, in my opinic	on, death occurred at	t the time, date a	and place	e, and due to the o	ause(s) and manner stated.	
To the within To the compl	Σ	only one) 3 29b. Signature and		Nurse Practioner: To the	best of my	knowledge, d	29c. License				s) and manner as		
(1)		Maren Mayhew CRVP (RO5) 293 10/12/12											
July 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
Stat	e	31. Date filed (Mont		NEW CKU	ar's Signat	801 N	1c(ormic	KUTL	argo	MD	a0 17	4	
Pagietre		li UC.	1 1 7 20	1) /2	A	Mar	Kal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANEC BLEDLER BROWNE October 12, 2012 12:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County PICKERSGILL ROSKOT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Apc 7, 1921 Director 219 -18 -1667 Macyland 1 M 2 X F 91 1 and 2 should ba filed within 72 hours after death with tha Maryland f Haalth and Mental Hygiana. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evantinar must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Towson 1 🗌 Yes 2 🎇 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 615 Chestnut Avenue USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Acchitectucal Elementary/Secondary (0-12) College (1-4 or 5+) 5-F Interior Design Decor Interior Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mason Paul McAllister Biedler Janet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 834 Hillside Road, Brooklandville, MD Rebecca B. Reynolds 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place 20c. Location - City or Town, State Dapertmant of I Important: If Ite eny Injury or ot 1 Burial 2 A Cremation 3 Removal from State Catonsville, Maryland Metro Crematory, Inc. 10/13/2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Viruseral crivice Linenses

duccin D. Lavson Mitcheff wiedefeld Funeral Home, 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician a. Our lications from coronary disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): attanding physician and for use as tha burlal-transit Cause (Disease or injury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Year Day signad by the at ba detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an paga 2 s has performed' Aftar this cartificata Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 1 No 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending To the Hospital or Attending within 24 hours eftar death. To the Funeral Diractor: Afta complately filled in by tha fur work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 700706 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Charles

31. Date filed (Month, Day, State Registrar

Donna M. Vincenti, MD

30. Name and address of person who completed cause of death (Item 23a)

OCME

Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E

October 3, 2012

12-07567

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ed Allen Black		S 1- For State Registrar	tate of Maryland / I		ent of He ate of De		Mental		Reg. No.	201	2 3333
Physici Medical Exami	an/	1. Decedent's Name (First, Midd Ted Allen B	ile,Last) Black					2. Date of Dea Month October 6		ear	3. Time of Death 0750 hrs
		4a. Facility Name (if not instituti Union Hospital	on, give street and number)		ity, Town, or L	ocation of D			y of Death		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If								rth(MM/DD/YY 8 / 1 9 7 6	E	
and f shuw any ince.	or	Usual Residence of Decedent 10a. State	1	oc. City, Town	or Location encer						10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a ur 28a-f shuw ust he mniffied at once.	Director	10e. Street and Number 349 Pup Run		Zip Code 25276			10g. Citizen of \ U	What Counti	ry?		
D 58	by Funeral	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di 15. Decedent's Education (Spe	ver in U.S. No eted) 16a						nite, etc. Whi '		
17215-0036 Id be filed within 72 hours after fental Hygiene. narked other than "natural", event, the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most o	f working life, [ed	DO NOT use	retired)	Disa	bled	
21215-0036 hould be filed within 77 ad Mental Hygiene. is marked other than tite event, the <u>Medical</u>	Be	17. Father's Name (First, Middle Kenneth E Bl	.ack				Jan	ame (First, Middle,	lagle	,	
MD 21 id 2 should ulth and Me m 27 is ma	To	19a. Informant's Name/Relation Kenneth B Bl						or Rural Route Nu e North	East	MD 2	1901
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and Important: If item 27 is r injury or other traumatic		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	pecify:		tory or other p		1	Date 0/13/12		Burı	nie MD
Balt permit. Depart Impor injury		21. Signature of Funeral Service	TALL		Thom	asAlle	enPA	7090 Ri	dge Rd	Hand	Fun Serv over MD
Physician /Medical Examiner		23a. Part I. Enter the disease, of failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line.	(Heroi						eart	Approximate Interval Between Onset and Death
**************************************	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequ							\dashv	
ed sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						-	
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F.O. E ires that the d signed by the	ā	Part II. Other significant condi	tions contributing to death b	ut not resultin	g in the under	lying cause giv	ven in Part I.			_	ne cause of death?
Records, The law require cate has been si	Completed										opsy findings available mpletion of cause of 2 No
Vital Rec ysician: The his certificate director, page	o Be (25. Was case referred to medical examiner? 1 ✓ Yes 2 No		2 🗹 ER/0	outpatient 3		ther -	eck only one) ursing Home 5	Residence 6	Other:	
n of \nding Ph. th. The After the funeral	ion: T	27. Manner of Death 1 Natural 5 Pen	28a, Date of Injury (Month, Day, Year		Time of Injury	1 TV	at Work?	subjec	how injury occu		in and
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Certification	2 X Accident 3 Suicide 4 Homicide Accident Accident Investigation Fending F								al Route Number, City	
To the Hosp within 24 ho To the Fund	Medical C	one) 2 Medical Exa	Physician: To the best of my kaminer:On the basis of examinand manner stated.			n my opinion,	death occurr		and place, and	I due to the	cause(s)
	2	29b. Signature and title of certifi			n D	29c. License O.C.M			29d. Date sig		h, Day, Year)
Ø		30. Name and address of person Russell Alexander Mi	D. Assistant-Medical	Examiner	900 W.	Baltimore S	Street, Ba	ltimore, MD 21	223		
S Regis	tate trar	31. Date filed (Month, Day Year)	32. Registrar's	1	Mal			OGME			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October dward 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** Apt 4b. City, Town, or Location of Death 4c. County of Death Millbrook Baltimore 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) **Funeral** Months Days Min. MD **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No 1+1 mara 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 0962 Mill brook 21 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify. Navu Blac 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) der should be filed with and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Park Millbrook 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Page 1 cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Carrison 21. Signat of Funeral Service Deensee 22. Name and Address of Facility trai 23a. Part 1: Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ischemic Bowel disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Due to (or as a consequence of): Examir Cause (Disease or iinjury that initiated events that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical Box 68760 phys. IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Year Pregnant at time of death Unknown 9 Unknown signed by the P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ scronary anteny disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed chronic Kidney disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Diabetes 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Yes 2 No 1 💹 Natural 5 Pending injury within 24 hours after death. To the Funeral Director; A the f Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed To the P 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Chaig Gold W 1838 G: Rene Tree Road 453088 October 10, 2012 Battimore, Maryland 1838 Greene Tree Road suite 135

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day,

7 2012

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2012 9:10 PM BRAZIER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death NORTHWEST HOSPITAL CENTER RANDALLSTOWN <u>BALTIMORE</u> Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Country) Director 187-40-7968 1 □ M 2 X) F 10/08/1948 MD 64 Usual Residence of Deceden or then "neturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours efter death with the Meryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 203 CONEWOOD AVENUE 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: Completed 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) end Mentel Hygiene. ie merked other then Elementary/Secondary (0-12) College (1-4 or 5+) TOUR GUIDE TRAVEL TOURISM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 permit. Pege 1 end 2 should be Department of Heelth end Ment Importent: if item 27 ie merke eny injury or other treumetic o ROBERT STEIN BETTE STONE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES BRAZIER/HUSBAND 203 CONEWOOD AVENUE, REISTERSTOWN, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION INC 10/16/2012 HAMPSTEAD, MD eny in 21. Signature of Funeral Service U 22. Name and Address of Facility $\,$ SOL $\,$ LEVINSON & BROS., $\,$ INC. REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician Arrest espisatory ardiac Medical resulting in death) Due to (or as a consequence of): Examiner ASCVI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). 24 hours efter deeth, Funder this certificate has been signed by the ettending physicien end Funderet Director. After this certificate has been signed by the ettending physicien end letely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Hospitei or Attending Physicien: The lew requires that the deeth certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 $^{\sim}$ Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2,□ No မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical To the Hospl within 24 hou To the Funer completely file 29a. Certifier 🚉 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0007619

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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October 16 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Boyars Ky Physician/ Samuel Month Year 6:45 P 2012 Medical october 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAI RANDALLSTOWN BALTIMORE . Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 218-18-7693 Hours Min. (Month, Day, Year) Director 1 X M 2 D F Usual Residence of Decedent 89 02/27/1923 POLAND permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified anone. 10b. County Director 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 ☐ Yes 2X No PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 POMONA EAST, #503 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWNER WINDOW CLEANING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 SOLOMON BOYARSKY IDA RESNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GERALDINE BOYARSKY/WIFE POMONA EAST, #503, PIKESVILLE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK 10/16/2012 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 0 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bladder Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): physician and is the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injurithat initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 $\mathscr{C}_{\mathscr{A}_{\mathscr{S}}}$ Due to (or as a consequence of): attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day certificate has been signed by the a lirector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) ٥ 1 🗌 Yes 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 24 hours after death. Funeral Director: After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after de To the Funeral Director completely filled in by th Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 113/CayapameMD DOOS 7465 14/12

State Registrar

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Baltimore MD 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

NSRajapaksemo

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Regional Prince Hospita George Ldurel aure Birthplace (State or Foreign Country) Social Security Number 1 Year If Under 24 Hrs. 6. Sex If Under 8. Date of Birth (Month, Day, Year) **Funeral** Days Director 580-10-5954 1 ☑ M 2 □ F or 28a-f show 10a. State 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2 □ No 5005.9Q all 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 070 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. should be filed within 72 hours aftrand Mental Hygiene.

is marked other than "natural", 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed, life, DO NOT use retired) Elementary/Secondary (0-12) esman Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname) ပ Department of Health and Important: If item 27 is m any injury or other traumaone. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland National May 10-20-2012 Signature of Funeral Service Licensee Yourel Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Chronic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnar 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown the 2 page 2 should be detached g | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe Hospital or Attending Physician: The 2 No Yes 2 No 1 Yes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 X No Other: 1 Yes ဂ္ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After it. Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Muse Practitioner: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner stated. 29a. Certifier Sertifying Marge Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) 10063580 10.13.2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 7360 Van Dusen Road Mina Regional Yacoub Laurel Hospita

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 19b, per fh, 2932 10-17-12 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Virainia Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltoma 10WSOY mhtvew Assista ousson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 16,1918 Funeral 7. Age (In yrs. last birthday) Days Hours Min 228-18-6993 Director 1 □ M 🛠 😾 F 94 Usual Residence of Decedent item 27 is markad other than "natural", or items 23e or 28a-f show other traumatic event, the Modical Evaniner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is markad other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examinar must he material and injury or other traumatic event, the Medical Examinar must he material and injury or other traumatic event. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Towson Baltimore Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 Funeral 20 E. Burke Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking-Own Home 12 vrs N/A Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Ellen Gardiner Edgar Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Get Lysburg) 81 Woodhaven Drive Gettsburg, Pa. 17325 David V. Cowger (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 10-13-2012 Parkwood Cemetery Baltimore, Md. 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 Uson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neciosis Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a nonsequence off Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. use as the burlal-transi To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlal-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 \ll Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the Vithin 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRNP RO7954 30. Name and address of person who com pleted cause of death (Item 23a) (Type, Print) IUSAN 31. Date filed (Month, Day, Year)

OCT 1 7 2012 Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month David Lee Crooks 2012 1812 Medical October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges' Medical Center Cheverly Prince George 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral Director** 252-62-8854 1 🛛 M 2 🗆 F Usual Residence of Decedent 71 June 3, 1941 28a-f show 10a. State Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 🛚 Yes 2 🗆 No MD Prince Georges Hyattsville 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2305 Lewisdale Drive 20783 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1

Yes 2 □ No
If Yes, Give
Year or Dates.1966 Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 'natural", 3 ☐ Widowed 4 🔀 Divorced Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Mail Carrier Federal other other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Johnnie Will Crooks Ivery Lee Caine 19a. Informant's Name/Relationship (Type, Print) 19b Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
119 Weymouth Street, Upper Marlboro,
20774 Department of Health ar Important: If item 27 is any injury or other trac Clara C. Jones/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans 10/15/2012 Cheltenham, MD Cem. eral Service License 22. Name and Address of Facility Austin Royster Funeral Home Street NW. Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of and -trar Due to (or as a consequence of) resulting in death) Last burial physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No g Unknown Unknown be detack signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an After this certificate has Yes 2 No 1 Yes 2 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) the funeral Manner of De Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work?
1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours a

72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

completely

Medical

29a. Certifier

31. Date filed (I

(Check

29b. Signature and title of certifier

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Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

9c. License numbe

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sanford Charlton Cockrell October 14 2012ª 1:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Blakehurst Care Center Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months (Month, Day, Year) Hours Min Director 427-28-5674 1 K M 2 D F 93 Yrs April 20 1919 Mississippi Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits the Maryland Director Maryland Baltimore Towson 1 Yes 2 TNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road Funeral 21204 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. 1950s Completed by 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Engineer General Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Sanford Cockrell Jeffie Duren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgie Cockrell 1055 West Joppa Road Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. Oct 17,2012 Baltimore, Maryland 21. Signature of Fameral Service Licenses 22. Name and Address of FaMilytchell-Wiedefeld Funeral Home Inc 6500 York Rd Baltimore, MD 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final -- Physician/ disease or condition resulting in death) Medical Examiner Ovonary Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 1 🛂 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Set Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sharon Mikem CRWF R048402 KO48402 10/16/2012 SHARON M. KERW, CIZNA, BINKEHUNST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MD 1055 St. JOPAA ROAS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 7 2012 Registrar

Baltimore. Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2012 6:12 P M Joseph Edward Cooney Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5016 Hornago Avenue Perry Hall Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) **Director** 579-36-0018 1 🛛 M 2 🗆 F 82 Usual Residence of Decedent 02/24/1930 Washington, DC 28a-f show 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a 21128 5016 Hornago Avenue U.S.A or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Education marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ပ Leo Coonev Etta Marie Brand 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anne Cooney / Spouse 5016_Hornago Avenue, Perry Hall, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 10/16/2012 | Hanover, Maryland 21. Sign sture of Funer Pervice Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician nson ANK disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) and Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical certificate be Box 68760 as the IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Yes 2 No the be detached g Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check 3 🗌 29b. Signature and title of certifie wa)

Registrar

State

31. Date filed (Month, Da

3a) (Type, Print)

of death (Item

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Examine		4a. Facility Name (if not institution,	give street and number)	•	4b. City	-	Location o			4c. County of Dea	ath .	
"Mayor"		5. Social Security Number	6. Sex 7. Age	(In yrs. last bi	irtholou) If I Inde	r 1 Year	US (a of Dieth	Da.	tt mo	re
Funeral Director		051-30-9674 Usual Residence of Decedent	1 M 2 F	Tic	Yrs. Months		Hours		e of Birth onth, Day, Yea	(r) 9.81 1926 N	rthplace (State	e or Foreign
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0 [5]	হ	11. Marital Status 1 ☐ Newer Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.		13. Was Dece If Yes, spe 1 \sum Yes	cify Cuba	n, Mexican	gin? (Specify Yes , Puerto Rican, e	or No- etc.)	14. Race - Am Black, Whi Specify:		الم
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ryla	의	Dennis H	ung	1			M	larth	a	King	·	11.5
Baltimore, Maryland 21215-0036 semit. Pege 1 end 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. mportant: if item 27 is marked other than "natural", only injury or other traumatic event, the Medical Event pres.		19a. Informant's Name/Relationsh	ip (Type, Print)	10	71-19 F	ine	Numbe Vi'lle	er or Rural Route	Number, City	or Town, State, 2 GHIELD	Garden	L, NY
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be ex beriar buria	ca	resulting in death) Last	Due to (or as a	a consequence	e of):	-						
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Division of Vital Records, P.O. Box 6876C to the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician between the funeral director, page 2 should be detected for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal dea	ath 3 🗌 Ectopic 5 🗎 Other (s		су			23d. Date of de Month	elivery Day	Year
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ivisio or Atter after dea Diractor	Certificate:	3 Suicide 6 Could 4 Homicide determ	not be	ury - At home, c. (Specify)	farm, street, facto			28f. Lo	cation (Street by or Town, St	and Number or Rate)	ural Route Nu	mber,
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical	(Check 2 ☐ Medical E	Physician: To the best of xaminer: On the basis of e	xamination and	I/or investigation, in	my opinio	on, death oc	ccurred at the tim	 e. date and plant 	ace, and due to the	cause(s) and	manner stated.
To the within To the compl	Σ	only one) 3 ☐ Certifying 29b. Signature and title of certifier	Nurse Practitioner: To the	e best of my kr	29	c. License	e number			Date signed (Mon		
		In re	of no			007	1063	5	10	0/14/1	2	
6		30. Name and address of person lawa Patel	wno completed cause of d & 761 N (L	eath (Item 23a	UTIVOC. FRIII	Te	4109	5 Bul	timo	of MD	uz	5
Stat		31. Date filed (Month, Day, Year)	32. Registry	's Signature	12. D.			- 0				
Registra DHMH 17 Rev 06-2	_	001 1 7 2012	person p	7								
K					RIGINAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 14^{ay} 201^{Yea} October 1:57 PM Hien Hoang Clayton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Catonsville 1103 Vineyard Hill Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 549-29-1103 **Director** 1 M 2 X F 8/2/1919 93 Vietnam Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md Catonsville 1 Yes 2 X No Baltimore 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 21228 7 Six Notches Court USA items 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Asian Year or Dates r than "natura the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) the 12Midwife Medical and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sinh V. Hoang Hanh T. Nguyen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 7 Six Notches Court Catonsville, Maryland 21228 Cau Hoang Son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Back telemore of Victory From Author V 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Loudon Park 10/20/12 Baltimore, Maryland 21. Signature of Funeral Service J 22. Name and Address of Facility Loudon Park Funeal Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph, i i n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performe 2 🗌 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred er death. eral Director. After Iy filled in by the 1XNatural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

within 24 hours at To the Funeral D completely filled

State Registrar

29a. Certifier only one)

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Marde

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D26256

choice Lave

29d. Date signed (Month, Day, Year)

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Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 16, 2012 JAMES RONCIE DUKE 8:00P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1307 Park Avenue Baltimore None 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Hours 265-26-0817 1 🕅 1 2 🗆 F Director 09/22/1924 Florida 88 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 28a-f shov 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland None Baltimore 1XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 1307 Park Avenue USA 12. Was Decedent Ever in U.S.

Agned Forces?

1/2 Yes 2 \[\] No

If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Medical Doctor Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roncie Renfro Duke Lorene Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 St Paul St Suite 1500 Baltimore, Maryland 21202 Frederick Koontz 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory 10/17/2012 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) ature of Funeral 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. 23a. Part 1. Enter the diseas Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani DISEASE ALZHEIMEZ disease or condition resulting in death) 10 years Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and I for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မှ 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier ZOIZ 45 D0053364 9

Registrar DHMH 17 Rev 06-2011

State

10755

MA

32. Registrar's Signature

SUITE 300

MD

21093

RS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33337 Certificate of Death s Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Gober 11. 8:27 AM Medical give street and number (if not institution. **Examiner** Town, or Location of Death owson 1108 Himore Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Дау, Birthplace (State or Foreign Country) Days Hours Min. **Director** 1 MM 2 □ F 927 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Detartment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Town or Location 10d. Inside City Limits Director atons Vil 1 Yes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. White, etc. 1 Dever Married 2 Married 호 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4 or 5+) Be ather's Name (First, Middle 18. Mother's Name (First, Middle, Maider ည uaenia Informant's Name/Relationship (Type, Print) 19b. Mailing Add Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 23a. Part 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ schemic disease or condition carlingo Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? Month 5 Other (specify) Day Year 1 Yes 2 9 Unknown been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Closhid in Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 1 N within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 | Nursing Home 5 | Residence 6 (Specify) NO 1 (10) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in manner is stated. Medical 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty 29d. Date signed (Month, Day, Year) 03 OCTOSES 2012 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 6 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Q08 AM Decker WILLIAM 400c Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Baltimore HOPKINS Hospital Johns Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Country) MD 219-40-4439 Months Hours Min **Director** 1 **X** M 2 □ F 09/15/1940 Usual Residence of Decede or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Manyland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10d. Inside City Limits 10b. Count 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 10a. State Halethorpe Baltimore MD 1 ☐ Yes 2 🔀 No 10f. Zip Code 21227 10e. Street and Number 10g. Citizen of What Country? Funeral USA 3233 Kessler Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical sonce. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Transportation Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname)
Lena Minerva Cline 17. Father's Name (First, Middle, Last) William Blair Decker, Jr. 19b. Mailing Address (Street and Number or Bural Route Number, City or Town, State, Zip Code) 1601 Fullerton Rd., Edgewater, MD 21037 19a. Informant's Name/Relationship (Type, Print) William Blair Decker, 4th/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other pl Arundel Crematory 10/20/2012 Odenton, MD W. 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ (sconar disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 as the t 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Yes signed by the a Id be detached f 1 Yes 2 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Tho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Certificate: To 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. Sora 1800 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

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State of Mar	yland / Department of H	lealth and Mental Hygiene	2012

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		4a. Facility Name (if not institution, give 7644 Allendale Circle			4b.	City, Town, or	r Location o		00.0001	4	c. County o		'e
Funeral	_	Social Security Number 6. Se	x 7. Age (Ir	n yrs. last bi		If Under 1 Yea	ar If Unde	er 24Hrs.	8. Date of Bi				hplace (State or
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any		Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	n or Location								10d. Inside City Limits
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Aaryland 28a-f show 1 at once.	Director	10e. Street and Number			1	Of. Zip Code			1	0g. Ci	tizen of Wh	at Coun	try?
the Nation		7644 Allendale C	Circle			207	785			US	SA		
th with ems 2.	Funeral	11. Marital Status 1 Never Married 2 Married	12, Was Decedent Eve Armed Forces?	er in U.S.		ecedent of Hi specify Cuba				-	14. Race White		can Indian, Black,
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		Toni M. Willis/ 20a. Method of Disposition				llendal			Hyatts				and 20785
F 8 7 7 7 8		1 Burial 2 Cremation 3	Removal from State	crema	tory or other	place)	- /					•	
Baltimo permit. Page Department o Important: injury or ott		4 Donation 5 Other Specify; 21. Sign of Funeral Service Li n		River		Cremato	ory	10-15	5-2012	K1	verda	.1e,	Maryland 1 Home,Inc.
Depa Injury		Syan Fix	u			4 Lando							
Physician		23a. Part I. Friter the disease, or complifailur. List only one cause on ear		death. Do n	_								Approximate Interval Between Onset and
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	Je.		Due to (or as a conseque						1011		CUIC		
	Examiner	(Disease or injury that initiated C.	Due to (or as a conseque	ence of):									1
760, icate be executed physician and the burial - transit		d.	AMENDED 23a-b	nt T	T 27 2	8a-f n	or mo	03/	12_4	_12	O.Th		
Box 68760, death certificate be executed the attending physician and I for use as the burial - trans	Medical	IF FEMALE:	23c. If yes, outcome o				CI MC	-,8734	12-4		d. Date of d	leliven.	
687(ertifica		23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fetal	death 3	Ectopic	c pregnanc	4	120	Month	D	ay Year
Box 687 death certifine the attending of for use as t	Physician/	1 Yes 2 No 9 Unknown	4 Pregnant at time 9 Unknown	e of death	5 Other	(Specify)							
he t		Part II. Other significant conditions	contributing to death bu	t not resultir	ng in the unde	erlying cause (given in Pa	art I.	23e. Did to	bacco	use contrib	oute to t	he cause of death?
S, P.O.	od be	Hypertensive Ath	eroscleroti	c Car	<u>diovas</u>	cular I)isea:	se:			AS PER	-1	ably 4 🗹 Unknown
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Rec The l ficate l	S	with impacted fo	eces						1 Yes	2 <u> </u>		✓ Yes	2 No
Vital Rec ysician: The his certificate director, page	å	25. Was case referred to medical examiner?	ospital: 1 Inpatient	2 FR/C	Outpatient 3		Other4		one)	Reside	ence 6 🗸	Other:	Scene
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ion teodio eath. for: A	ţ	1 Natural 5 Pending 2 Accident Investigation	fd 10_10_	-12 fd	23:30	pm 1 .	Yes 2 X	No u	nknown				
Division of Vital Records, To the Hospital or Atteodiog Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should be	Certification;	3 Suicide 6 X Could not be determined	28e. Place of Injury	- At home, f		actory, office b	ouilding, etc	- 1-	f. Location (S or Town, S	tate)	644 A	or Rur 11ei	al Route Number, City
Cospita Hours huneral	S	29a. Certifier Cortifier Physicia	(Specify) an: To the best of my known				ata and nla		andove			as state	4
o the Fithin 24	Medical	one) 2 Medical Examiner:											
F 3 F 3	Me	29b. Signature and title of certifier	and the mot stated.			29c. Licens	e number			29d.	Date signe	d (Mon	h, Day, Year)
7		unes 2				O.C.	M.E.			Oct	ober 11,	2012	
4 1	-[30. Name and address of person who can Ana Rubio M.D., Ph. D.	ompleted cause of death Assistant Medical		r 900 W	. Baltimore	e Street	Baltimo	re, MD 21	223			
St	ate	31. Date fill CTth Pay Year 1	32. Registrar's S		/								
Regist	rar	001 1 7 2012	Deneva	B. A	arkal				OOME				
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33340 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ P^{M} October 2012 7:55 Wilson Cary Nicholas deRussv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester <u>Atlantic General Hospital</u> Berlin Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min Days Hours **Director** 217-40-9891 1 XM 2 F 09/02/1942 Maryland 70 Usual Residence of Decedent r 28a-f show 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Berlin MD Worcester 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral U.S.A. 21811 5 Brookside Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. ģ 1 Never Married 2 Married X Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 X Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Publishing Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Miriam Ross McGarvev Nicholas Edward deRussy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 412 Chesapeake Avenue, Stevensville, MD 21666 David deRussy / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 10/12/2012 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry Funeral Service 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Obstructive Lung disease After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 Wilson Derussy DOB 9/21 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury work?
1 Yes 2 No 5 Pending Investigation the 1 Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 0/11 20/2 Kund D74353 apleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who

State

Registrar

Vikas Sayal,

7 2012

31. Date filed (Month, Day, Year)

9733 Healthway Drive, Berlin, MD 21811

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia Medic	_	Virginia H		Enoc	ch				Octobe	Pr Day	4 201	2 1:30	$ ho_{\scriptscriptstyle{M}}$
Examin		4a. Facility Namblif not institution, give	ties Cer	nter		4b. City, Town, or RIVE	rda	le	-	PV	ounty of Dea	George	,
Funeral Director		5. Social Security Number 6. S 244-24-4447	ex 7. Ag	je (In yrs. la 9]	as <i>t birthday)</i> L Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birl (Month, Da	y, Year)	Co	rthplace (State or Foi ountry)	0
at at	_	Usual Residence of Decedent 10a. State 10b. County			y, Town or Loc	ation	<u> </u>		Sept.	, 19.	Z1 Sou	th Caroli	
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F', or i	φ	1 ☐ Never Married 2 █ M arried 3 X X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛭 If Yes, Give	No		Yes, specify Cuba ☐ Yes 2 🗓 No			Rican, etc.)	S	Black, Whit	te, etc. .ack	
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than "	Completed	(Specify only highest gr	College (1-4 or	5+)	life. DC	ind of work done of NOT use retired) Service	_			ъ	rivate		
perfilt. Tage 1 and 2 should be may writh. 2 hours after death with the way yan uportant; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Be	12th 17. Father's Name (First, Middle, Last)			roou	Service	18. Moth	er's Name	e (First, Middle,				
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t of He If item or othe		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		20b. P	lace of Disposemetery, crem	sition (Name of latory or other place	ce)	I	Date	20c. Loca	ation - City o	r Town, State	
artmen ortant: injury		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licens		No	rth Lav	vn Cemete	ery	10-22	2-2012	Burl	ington	NC Home, In	<u>.</u>
Deport		Naphney N	· Corne	lius	\mathcal{Q}	7474 Lar	ndove	r Roa	ad Hyat	tsvi1			
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been signed by the attending physician should be detached for use as the buria	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant a g ☐ Unknown	at time of c	death 5	Other (specify)					Month	Day Year	
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vithin 24	Me		se Practitioner: To the				the time, da			the cause(s)		as stated.	
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139h		30. Name and address of person who	completed cause of d	death (Item	23a) (Type, P	DVIVE	EIK.	nda	e Ma	wil	and	15, 201.	,
Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat		VIIVE			1 1000	10100	0000		
Registra	ar	UCT 1 7 2012	15.	1	1								

DHMH 17 Rev 06-2011

12-07813 Charles Fuller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 33342 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle,Last) Physician/ Month Day October 14, 2012 2020 hrs **Medical Examiner** Charles Fuller 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** Foreign Hours Months Davs 12/2/92 Director 218-37-6506 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits 10a. State MD 10c. City, Town or Location Baltimore any N/A 1 Yes 2 No s 23a or 28a-f show a notified at once. Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatie event, the Medical Examiner must be notified at annea Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21205 USA 612 N. Potomac St. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? African Yes Specify: Amer. 1 Yes 2 No specify: If Yes, Give Yeer 3 Widowed 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Warehouse Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 21215-0036 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kelita Elkey Charles Edward Fuller, Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Baltimore, MD 612 N. Potomac St., Balt., MD 21205 Kelita Elkey/Mother Date 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/20/12 Balt/MD Bayview Crematory 4 Donation 5 Other Specify: permit. 22. Name and Address of Facility Hari P. Close F.Svs, PA 21. Signature of Fuln and Service Licenses Belair Rd, Balt., MD 21206-5105 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a gunshot wounds (2) of back (1) and left buttock (1) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED the attending physician led for use as the burial Box 68760 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown <u>6</u> Completed 24b. Were autopsy findings available peen 24a. Was an prior to completion of cause of autopsy certificate has performed?

✓ Yes 2 No death? director, page 2 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes ٦No 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification Subject shot Oct 14, 2012 within 24 hours after deau.

To the Funeral Director: A Natural 1 Yes 2 ✔ No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 6 Could not be 3 | Suicide or Town, State) 3000 E. Baltimore Street, Baltimore, MD (Specify) Sidewalk 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Registrar DHMH 17 Rev 1/2001

OCME 2006

State

ORIGINAL

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD. 31. Date filed (Month, Day, Year)

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

OCAME

October 15, 2012

12-07758 Michael Feldman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Michael Feidman	State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Certificate of Death Reg. No.	4
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year October 13, 2012 3. Time of Death Month Day 1. Decedent's Name (First, Middle,Last) 0637 hrs	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death St. Agnes Hospital 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 218-74-1114 6. Sex 7. Age (In yrs. last birthday) 1	
nd how any ce.	Usual Residence of Decedent 10a. State	
the Maryland so 28a-f show tiffed at once.	10e. Street and Number 2807 Virginia Ave. 10f. Zip Code 21227 USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "saturar", or items 23a or 28a-f shot injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes (12 Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry	_
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica for the Medica for the Medica	17. Father's Name (First, Middle, Last) Gary Morgereth Cecelia Berger	
MD 2. nd 2 should ulth and M m 27 is m aumatic o	19a. Informant's Name/Relationship (Type, Print) Lisa G. Feldman / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 2807 Virginia Ave., Baltimore, MD 21227	
Baltimore, permit. Pages I and Department of Heal Department of Heal Important: If then injury or other tra	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, or other place) W. Arundel Crematory 10/15/2012 20c. Location - City or Town, State Odenton, MD	
Baf; permii Depar Impo	1025 THIRD TIP THE PARTY T	
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Approximate Interval Between Onset and Death Death	
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P.O. B s that the d gned by the d detached by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?	
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Vital Recysician: The linis certificate director, page	25. Was case referred to medical 26.Place of Death (Check only one) 25. Was case referred to medical 26.Place of Death (Check only one)	_
f Vital Physician Pris cert ral director	examiner? 1 Yes 2 No 1 No Spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	- 13
ion of trending Ph leath. tor: After t the funeral	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending 2 Accident Investigation	
Division or spiral or Attending hours after death the meral Direct death of filled in by the fune Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)	/
2 \$ 2 5 8 8	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
) į	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 14, 2012	
ϕ	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar		_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ OA Medical Facility Name (if not institution five street and number) Examiner 4b. City, Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday **Funeral** Hours 217-12-0007 **Director** 1 M 2 X X 88 06-13-1924 Maryland ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2XXNo Hanover 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by Funeral 7560 Race Road 21076 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ Yes 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X X No 3 ¥ Widowed 4 □ Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank Farace Josephine Dalfonzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy F. Fischbach - son 7560 Race Road, Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem Pk. 10-12-2012 Elkridge, Maryland once. 21. Signature of Fureral Servia 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Inc. 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Duges Medical resulting in death) Due to (or as a consequence of) **Examiner** OUGUE Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of) as the burialthe attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy for in the past 12 Month 5 Other (specify) Year Pregnant at time of death Yes 2 No detached 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? within 24 hours after death.

To the Funeral Director, After this certificate I completely filled in by the funeral director, pag the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 7 No မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 🔁 Natural 5 Pending 2 🗆 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year) 30 Name and address of person 31. Date filed (Month. Dav. Year) State Registrar

DHMH 17 Rev 06-2011

12-07443 Michael William Fanelli

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 33345

		1-For State Certificate of Death Registrar		eg. No.	
Physici		Decedent's Name (First, Middle,Last)	Date of Dea Month		3. Time of Death
edical Exam	iner	Michael William Fanelli 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	Month October	4c. County of	2013 hrs
		634 Cole Street #6 Perryville		Cecil	Dodan
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs			9. Birthplace (State or
Director		112-42-8619 1 M 2 F 61 Yrs. Months Days Hours Min	01/1	4/1951	Country) New York
ay		Usual Residence of Decedent 10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
d how a	_	MD Cecil Perryville			1 X Yes 2 No
arylan 8a-f sl	cto	10e. Street and Number 10f. Zip Code	T.	l0g. Citizen of What	t Country?
the M Saor 2	Dir	634 Cole Street, #6 21903	ĺ	U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Stanish	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No	14. Race - A White, 6	American Indian, Black,
er dea , or it		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify:	
ours aff tural' aming	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of vice in the complete in the co		16b. Kind of Busin	White ness/Industry
6 72 ho rn "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	ired)		
within itene.	omo	5+ Physics Professor		Educat	
215-0036 be filed within 7 and Hygiene. rked other than ent, the Medica	Be C	17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name	e (First, Middle,	Maiden Surname)	Unknown
212 ould bould by Ment	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	Rural Route Nur	nber, City or Town,	State, Zip Code)
MD and 2 sho alth and m 27 is		Gail Wyant / Friend 129 Fernwood Road, Co			
of Hez If itel		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - C	ity or Town, State
Baltimore, permit. Pages I an Department of Hea important: If iten					r, Maryland
Bait permit. Departu Importi injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Apr. 7522 Connelley Dr.	-	•	*
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	•		Approximate Interval
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a, Hypertensive Atherosclerotic Cardiovascular Disease			Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): b.			
	Jer	if any, leading to immediate Due to (or as a consequence of):			
	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last use to (or as a consequence of):			
cuted ind transit		dd.			
760, icate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
8760, ificate be ig physici s the buri		IF FEMALE: 23b. Was decedent pregnant in the page 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancv	23d. Date of de Month	livery Day Year
Box 687 death certifics he attending p	Physician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		Monai	Day 10al
C. Bc the dea by the a	Phys	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did to	phaces use contribu	te to the cause of death?
i, P.O.	þ	Diabetes Mellitus			Probably 4 Unknown
rds, require been si thould b	Completed		24a. Was		re autopsy findings available
ecol ne law te has l ge 2 sh	d			rmed? dea	
tal Recian: The certificate ector, page		25. Was case referred to medical 26.Place of Death (Check		2 10 1	Yes 2 No
Vita hysicia this ce	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	ng Home 5	Residence 6 🗸	Other: Scene
Division of Vital Records, rat or stending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	J: L	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe	now injury occurred	
SiOn Attender r death ector: by the	cati	Accident Investigation 1 Yes 2 No 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc.	29f Looption (Street and Number	or Rural Route Number, City
Divisipital or At ours after d teral Direct filled in by	Certification:	Suicide Gould not be determined Georgia (Specify)	or Town, S		or Rural Route Number, City
Hos Fur h		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the caus	e(s) and manner as	stated.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date		
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. OCME			(Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)		October 9, 20	712
10		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B.	altimore, MI	21223	
	ate	31. Date filed (Month, Day, Year) OCT 1 7 2012 32. Registrar's Signature			
Regis	16.1	UUI I (701/ /Wayna / A Marka			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 33346

evin Allan Ferç		1- For State Certificate of Death	
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Tim	ne of Death
Medical Exam	ner	Kevin Allan Ferguson October 7, 2012	224 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace Months Dave Hours Min	e (State or
Director		220-13-6307 1 M 2 F 29 Yrs. Months Days Hours Min. 07/31/1983 Foreign Country Co	North Carolina
япу		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. It	Inside City Limits
* .	اِي	MD Anne Arundel Riva	Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
with the Maryland ns 23a or 28a-f sho be notified at once.	ij	3034 Rock Drive 21140 U.S.A.	E Dil-
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Inc. White, etc.	giari, black,
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23s or 28s-f she Medical Examiner must be notified at once	by Fu	3 Wildowed 4 Divorced in res. Sive real The Security. White	
5-0036 led within 72 hours after lygiene. other than "natural", the Medical Examiner	pe p	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry during most of working life. DO NOT use retired)	у
36 hin 72 e. than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cashier Seafood	
P 2 7 2 4			
21215-00; ould be filed with 1 Mental Hygiene 5 marked other t	o Be		ode)
		Allan H. Ferguson / Father 3034 Rock Drive, Riva, MD 21140	,
G 6 8 7	li	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, crematory or other place)	State
Baltimore, permit. Pages I as Department of He Important: If ite		4 X Donation 5 Other Specify: Anatomy Gifts Registry 10/15/2012 Hanover, Mary	
Baltimo permit. Pages Department o Important: injury or oth		21. Signature of Fundral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart App	proximate Interval
Medical Examiner		Immediate Cause (Final disease a. Asthma	Death
		or condition resulting in death) Due to (or as a consequence of):	
	Je l	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause	
	E I	c. (Janesa or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
ecuted and transi	E E	d.	
OX 68760, and certificate be executed attending physician and for use as the burial - transit	Medical Examiner	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
3876 rtificat ing phy as the	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day	Year
Box 687 s death certifice the attending pled for use as th	Physician/N	4 Pregnant at time of death 5 Other (Specify)	9
that the d			-
s, P.O. sirres that the signed by d be detacl	Completed by	Hypertensive Cardiovascular Disease, Sacoidosis	
ords, P aw requires t as been sign 2 should be c	plet	24a. Was an 24b. Were autopsy f profromed? death?	
Rec The I	Com	1 ✓ Yes 2 No 1 ✓ Yes	2 No
of Vital Records, ag Physician: The law requir ther this certificate has been s meral director, page 2 should l	Be	25. Was case referred to medical examiner? 4. Was a 2 Na	0
of \ ug Phy ug Phy uneral c	을 :		
Sion of Attending Ph or death. rector: After the funeral	gi	1 X Natural 5 Pending 1 Yes 2 No Investigation	1 N 1 - 0
Division pital o Attendio ours after death. neral Director A	Certification:	3 Suicide 6 Could not be determined determined (Specify)	ute Number, City
Hospit 24 hour Funcri			
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after deat: To the Funeral Director. After this certificate has been signed by the atter completely filled it by the funeral director, page 2 should be detached for u	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	
	Σ	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Company) October 7, 2012	ay, Year)
Th.		30. Name and address of person who completed cause of death (Item 23a)	
Ψ		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
S Regis	tate		

GUNN, NILEN Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gunn OCTOBER Medical ZOIZ 4a. Facility Name (if not institution, give street and number) 4c. County of Deat Examiner 4b. City, Town, or Location of Death 200 SAMARITAN NIA HOSPITAL LTIMORE If Under 1 Year | If Under 24 Hrs. ocial Security Number 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) g. Birthplace (State or Foreign 223.46.1888 Hours Country) Director 1 🗆 M 2 😿 F 8 1931 03 13 or than "natural", or items 23a or 28a-f show 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore MD 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1317 Hillsway Funeral Court 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Mantal Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Domestic Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Wilson Stella Farmer 19a. Informant's Name/Relationship (Type, Print) 1 end 2 shound Health and item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Brown / 317 Hillsway Court Baltimore MID 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: if its any injury or of 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Druid Ridge Cemeter 1020/2012 Pikesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funera (Services Road *sbert* Bandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head ailure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Myocardial disease or condition resulting in death) 17toviction Medical Due to (or as a consequence of): Examiner Corchery heart Disease

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician end for use as the burial-transit Cardiomyopathi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No 4 Pregnant at time of death Month by the 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, been signature Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 After this certificate has autopsy death? performed7
☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "within 24 hours after death.
To the Funeral Director: After this certifica Division of Vital funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completely filled in by the 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Do062689 Kathleon OCTOBER 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOCH RAVEN BLUD SHAFFER M.D 32. Regist State Registrar

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2 1 2 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 8, 2012 Year Physician/ 6:20 Рм Albert George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charles 2750 Homecoming Lane Waldorf If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1920 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Min. 1 X M 2 D F Hours Nov. Pay, Year 19 Georgia 255-16-9340 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director GA Ware Waycross 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1008 James Lane 31501 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Melissa Williams Willie Royals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretal Whitehead (Granddaughter)125 Sprucepine Drive Raeford, NC 28376 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Buyar 2 Cremation 3 Removal from State cemetery, crematory or other place Hazzard Hill Cem. 10-13-12 Waycross, GA 4 Donation 5 Other (Specify) ure of Fu eral Service Lit Metropolitan Filmeral Service 5517 Vine St., Alexandria, VA 22310 un 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ance disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Signary Pregnant at time of death Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Granddaughter's
4 Nursing Home 5 Residence 6 X Other (Specify) Residence Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural injury work 5 Pending after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2012 Golaboski Paul 12:15 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Davs (Month, Day, Year) **Director** 217-16-3946 1 X M 2 D F 88 Maryland 07/06/1924 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore Sparrows Point 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral Items 23a 2920 Wells Avenue 21219 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates. Black, White, etc. ŏ δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 X Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Longshoreman Shipping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ဥ traumatic Peter Paul Golaboski Victoria Rynarzeski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 Is eny Injury or other trau once. 227 Reba Drive, New Oxford, PA 17350 William H. Jubb, Jr. / Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 10/12/2012 4 ☑ Donation 5 ☐ Other (Specify) | Hanover, Maryland 21. Signature of Fun ral Service 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ cances disease or condition resulting in death) MICO cer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): physician and s the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: for use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Pregnant at time of death Day signed by the a Id be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, cate has been sig page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No Division of Vital the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) WDSPUL 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Accident Investigation □ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) OCPUBE 12 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles CT DW SUN CHANGE M) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 201 Registrar

DHMH 17 Rev 06-2011

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hysic his ce al direc	၉	examiner? 1 Yes 2 2					ER/Outpati		DOA Othe	r: 4 🗆 N	ursing Hor	ne 5 X R esi	dence	6 😾 Other	(Specify)	Daugh	ter's
tending Peeth. or: After the funera	Certificate:	27. Manner of Death 1 Natural 2 Accident 3 Suicide	n 5 ☐ Pending Investig 6 ☐ Could n	ation	e of injur onth, Day	y Year)	28b. Time injury	of M	28c. Injury work? 1 □ `	at	2	8d. Describe I	now inju	ry occurred	d	restu	ence
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the Hosp nin 24 hou the Funer npieteiy fi	Medical	(Check 2		Physician: To the taminer: On the ba Nurse Practitions	asis of ex	amination	and/or inve	stigation	, in my opinio	n, death o	ccurred at	the time, date a	and place	e, and due t	to the cau	se(s) and ma	anner stated.
vit To 1		29b. Signature and t	title of certifier	4 (oloc	Lone	ato	MD		29c. License 0 65 5					ate signed		ay, Year) 3, 20	210
2			e Colo	ho completed car	use of de	eath (Item 5Pa	23a) (Type,					vings					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ortober 20/2 Jeh 0 12:00 A M Medical Eacility Name (if not institution, give stre Aune t vn, or Location of Death Examiner Medical Glen Burnie Washington altimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 236-32-5154 Director 1 ☐ M 2 🟋 F WEST 88 01/20/1924 VIRGINIA Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD ANNE ARUNDEL PASADENA 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 350 BAR HARBOR ROAD 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 XWidowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) LABORER ESSKAY MEATS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES BENNETT **ETHEL** SHIPP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM GEHO, JR. / SON 350 BAR HARBOR ROAD, PASADENA, MD. 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place; GLEN HAVEN CEM. 10/19/12 GLEN BURNIE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Licensee 22 Nam 1. T. 700 Name and Address of Eachith INC. 00 S. CONKLING STE FUNERAL HOME STREET, BALTO., MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Carcinoma Jastric disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transi that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy this certificate 1 ☐ Yes 2 ☐ No 1 TYes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 DKNo Inpatient 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Donth 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, de 29b. Signature 68240 çause of death (Item 23a) (Type, Print) ame and address of person who completed 30 Huspita orkhov Vadim 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene [For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FRANCES ELIZABETH JONES HENRY Year 13, 2012 October | 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FUTURE CARE AT CHESAPEAKE Arnold Anne Arundel County If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Sept 21, 1919 South Carolina 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 7 F Days 93 **247-14-3952** Director Usual Residence of Decedent 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Mudical Examiner must be notified at Maryland | Anne Arundel County Directo 1 ☐ Yes 2 No Acnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 305 College Packway 238 21012 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Lorenzo Jones Clyde Weldon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau Mc. Charles H. Henry (Son) 1011 Old Bacn Road, Packton, Maryland 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Oruid Ridge Mausoleum 10/17/2012 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur / Fund Servin Cody & Wartin D. Lawson 22. Name and Address of Facility
MITCHELL-WIEDERELD FUNERAL HOME, INC
6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Demenha **Physician** /Medical Examiner Sequentially list conditions, if any locating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery signed by the atter 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No has autopsy of Vital 1 Yes 2 3 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 ursing Home 5 Residence 6 Other (Specify) al or Attending Fra s after death. the funeral 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 E-Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00073574 address of person who completed cause of death (Item 23a) (Type, Print) ,8601 Veferones Muy, fuite 204 Karmova.

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signatu

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		•	For State Registrar	State of Maryland /	Certificate of L		Reg. I	- 21117	33353
	Physicia Medic		1. Decedent's Name (First, Middle, Last)		Herman	7	2. Date of Death OCTOBER	13,2012	3. Time of Death 21:52pM
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	Funeral Director			M 2 F P P P	irthday) If Under 1 Year Months Days Yrs.	If Under 24 Hrs. Hours Min,	8. Date of Birth (Month, Day, Year	g. Birthp Count	lace (State or Foreign ry)
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	the Mar t or 28a- se notifie	I Director	10e. Street and Number Av	e. 101	10f. Zip Code		10g.	Citizen of What Coun	1 No le le le le le le le le le le le le le
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Ba	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	H101443	87/7 Gr	een Pasto	res Dr. f	Selto/M	021286
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C	Ph_sician/ Medical	8 19	disease or condition resulting in death)	Due to (or as a consequence	e of):	mage			
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68760	eath certificate be e attending physicia d for use as the buc	/Мес	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy				23d. Date of delive	
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Records,	v require	Completed					24a. Was an	24b. Were autop	sy findings available
Rec	The law cate has page 2	Comp					autopsy performed? 1 \square Yes 2	death?	npletion of cause of 2 No
of Vital	ysician: The iis certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 → No Ho	spital:	Oth	er:	k only one) ome 5 Residence	6 Other (Specify)	
of	ding Phy th. After this funeral o		27. Manner of Peath 1 Natural 5 Pending		. Time of 28c. Injurinjury work	y at k?	28d. Describe how inj		
Division	I or Attendir after death. Director: Af d in by the fu	Certificate:	2 X Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home,	7:30p	Yes 2 X No	fall from 28f. Location (Street a	and Number or Rural	Route Number,
Div	oital or ours afte eral Dire			building, etc. (Specify) residence			City or Town, Sta	saltimore,	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse	ian: To the best of my knowledge r: On the basis of examination and Practitioner: To the best of my kn	l/or investigation, in my opinion owledge, death occurred at t	on, death occurred at the time, date and pla	t the time, date and pla ace, and due to the cau	ce, and due to the cau ise(s) and manner as s	se(s) and manner stated. tated.
	With Com	1=	30. Name and address of person who con ATUL (Month, Day, Year) 31. Date filed (Month, Day, Year)	D	29c. Licenso	5-00() 0C	toper 15	Pay, Year) 3,2012
	(12)84		30. Name and address of person who con	npleted cause of death (Item 23a	(Type, Print)	15 St F	Paltimor.	e MD 2	1287
	Sta Registra	e	31. Date filed (Month, Day, Year) OCT 1 6 201	32 Registrar's Signature	fall				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	State of N	naryiani		artmen rtificate			anu iv	nemai ny	giene Reg. No.	20	12	333
hysicia: Medic		Decedent's Name (First, Middle Louis Edward	Hrebar							2. Date of De Month / O	eath Day) 2C	ear 12	3. Time of Death 5:26 f
Examine	er	4a. Facility Name (if not institution	,			4b. City,	Town, or	Location	of Death		4c.	County of I	Death	
uneral		Meritus Medica 5. Social Security Number		ge (In yrs. la	st birthday)	_ If Under		town If Under	24 Hrs.	8. Date of Bi	th	Wash 9		On ace (State or Fore
rector		175-30-0612	1 X M 2 □ F	- A	Yrs.	Months	Days	Hours	Min.	(Month, Da	ay, Year)		Countr	y)
at at	_	Usual Residence of Decedent 10a, State 10b, County		74	, Town or Lo	cation			<u> </u>	01/19	/1938	3 P		sylvania d. Inside City Lim
ified a	ecto	MD Mont	gomery		ermant					•				1 X Yes 2 🗆
or 28	흐	10e. Street and Number	gomery	1	Lillatic	10f. Zip	Code				10g. Citi	izen of Wha	t Countr	y?
nust I	Funeral Director	20906 Tall Fore				2	0876				U	.S.A.		
or iten		11. Marital Status1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces	?		Was Decede f Yes, speci	ent of His ify Cubar	spanic Ori n, Mexical	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V		
ral", c	ed by	3 Widowed 4 X Divorced	15 1/2 - 00	□ NO		1 Yes 2	oN 🗷 2	Specify				Specify:	Whi	te
"natu	plet	15. Deceder (Specify only highe	nt's Education est grade completed)	- 4		dent's Usual kind of work			t of worki	ina	16b. Ki	nd of Busin		
than he Me	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	life. D	o not use dyman	retired)			9		a.a. a.k	-~	
is marked other than "natural", aumatic event, the Medical Exa	Be	17. Father's Name (First, Middle, L	.ast)		пан	uyman	Т	18. Moth	er's Name	e (First, Middle,		onstri Surname)	JCCI	On
arked atic ev	유	Louis John	Hrebar						ancis		Oshal			
' is ma		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbi	er or Rura	al Route Numbe	er, City or	Town, State	, Zip Co	ide)
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		Holly F. Coope:	r / Daughtei		20906 ace of Dispo			rest		e, Gerr		own , M		
y or o		1 ☐ Burial 2 ☐ Cremation 4 🛣 Donation 5 ☐ Other (S		e ce	emetery, cren	natory or ot	her place			Date - (2012				
y injur		21. Sign ture of Funeral Service L		Allo	atony Gi	. Name and				5/2012 Anatomy		over, ts Red		
any ir		1	XX						Dr.	, Ste.	Р, На		~	D 21076
sician/ edical miner		23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lin	a conseque	1510.	sfy sfy	of dying	, such as	cardiac c	1228	rest,	1001		Approximate nterval Between poset and Death
tis .	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Sue to for as	Contend	ence oil:	Vac			da	CACC.	(0)	avvi	1	Maryu
		Cause (Disease or injury that initiated events resulting in death) Last	c. D (or as	a conseque	ence of):	act.			310				1	aaa
pnysiciar s the buri	edical		d	nei	M					<u> </u>			1	dif
completely filled in by the funeral director, page 2 should be detached for use as the	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 🗌 Fetal at time of de	death 3	Ectopic po Other (spe	regnancy ecify)	′			2	23d. Date of Month		day Vear
be det	à	Part II. Other significant condition	ons contributing to death	but not resu	ılting in the u	inderlying ca	ause give	en in Part	l.	11				cause of death?
hould	eted	/	Typeries	1810	γ		L			1		,		bly 4 Donkno
page 2 s	Completed		Den	ON.	uc					24a. Was auto perfo 1 Yes	psy ormed?	prior deat	to comp	y findings availab pletion of cause c
rector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othe	,,		only one)				
er mis neral d	e: To	27. Manner of Death	28a. Date of inj	ury :	R/Outpatier 28b. Time of		Bc. Injury	4 ∟ Nı at		me 5 Resi			pecify)	
the fur	ficat	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation	ay, year)	injury	М	work?	res 2 🗆	No					
t d ui be	l Certificate:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	inad 28e. Place of In	jury - At hor tc. (Specify)	ne, farm, stre	eet, factory,	office			28f. Location (S City or Tov		Number or	Rural R	oute Number,
pletely fill	Medical	(Check	Physician: To the best o xaminer: On the basis of Nurse Practitioner: To the	examination	and/or invest	tigation, in m	ry opinior	n, death o	curred at	the time, date a	and place,	and due to 1	the cause	e(s) and manner st
com		29b. Signature and title of certifier					License		-01	7	· · · · · ·	signed (Me		
	-	30. Name, and address of person v	who completed cause of	death (Itam)	23a) (Time 2	L'int)	100	45	08	(00	T 11 c	201	2:
		SHAMB Z	SIDDIC	3111	32	4	FA	nle	eta	in 87	H	AG, A	10	21740
State egistra	_	31. Date filed (Month, Day, Year) OCT 1 7 20		rar's Signate	Low	1								

12-07481 Debbie Hoffman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 33355

		1- For State Registrar		Cert	ificate of	Death			R	eg. No.	
Physicia edical Exami								2	2. Date of Dea Month October 2	Day Yea	3. Time of Death 2020 hrs
		4a. Facility Name (if not instited 603 Sligo Avenue #	ution, give street and number)		1	b. City, Town, o Silver Spri		of Death		4c. County of Montgon	
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. las	st birthday)	If Under 1 Ye					9. Birthplace (State or Foreign
Director		unk	1 M 2 KF	54	Yrs.	Months Da	ys Hour	s Min.	02/20	/1958	Country)MD
any		Usual Residence of Deceder 10a. State 10b. Cour	nty	4.	own or Locati						10d. Inside City Limits
Maryland 28a-f show d at once,	0		tgomery	S	Silver	Sprin	g				1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once,	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What 603 Sligo Ave #307 20910 USA									at Country?
with th		11. Marital Status	12. Was Decedent			Decedent of H	ispanic Ori				- American Indian, Black,
r death or iten	Funeral	1 Never Married 2	1 Yes 2	No		es, specify Cuba			ican, etc.)	White	
urs afte	þ		Divorced If Yes, Give Year or Dates: Specify only highest grade con	npleted)		Yes 2X N 's Usual Occup			rk done	Specify: 16b. Kind of Bus	White siness/Industry
6 1.72 ho	Completed	Elementary/Secondary (0-		5+)	_	st of working lif			d)	Desire	
15-0036 filed within 72 I Hygiene, ed other than "	mo.	17. Father's Name (First, Mid	_		Grapii	ic Des	_		First Middle	Print Maiden Surname)	-
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she umatic event, the Medical Examiner must be notified at once	Be	Gerald Hof	fman				Et	hel	Ann S	heeley	
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	ဠ	19a. Informant's Name/Relati John C Kere		Agent							n, State, Zip Code)
- 25 8 8 8		20a. Method of Disposition		20b. Pla		tion (Name of c			Date		City or Town, State
Baltimore, permit. Pages 1 an Department of Hea Important. If ite.		1 XBurial 2 Crema 4 Donation 5 Other	tion 3 Removal from Stanspecify:	Ho]	Ly Cro	ss Cen			2/12	Manro	Contractor Contractor
Balti permit. Departm Importu injury o		21. or of Funeral Serv	$\cdot \wedge \cdot /$		22. N	ame and Addres	s of Facilit	Simp	licit	y Crem	& Fun Serv
Physician	e	23a. art I. Enter the disease	or complications that caused	the death. [I Th Do not enter th	omasAl e mode of dying	LenP , such as d	A 70 cardiac or r	90 Ri espiratory arr	dge Rd est, shock, or hea	
/Medical Examiner		failure. List only one cal Immediate Cause (Final dise	a. Atheroscl			Lovascu	lar D	iseas	e		Between Onset and Death
4		or condition resulting in death	Due to (or as a conse	equence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	Due to (or as a conse	equence of):							
sit sit	Examiner	(Disease or injury that initiate events resulting in death) La		equence of):							
760, ficate be executed g physician and the burial - transi	/Medical	X UNPENDED	d AMENDED 23a	,27,pe	er me,g	933 11-	14-12	2 sm			
. 00	n/Me	∦F FEMALE: 23b. Was decedent pregnant i	23c. If yes, outcor			al death 3	Ectonic	c pregnanc	·v	23d. Date of o	delivery Day Year
Box 68 te death certil the attending	Physicia	past 12 months? 1 Yes 2 No 9	4 Pregnant at		h 🗔	er (Specify)	zotopi	o programa		in on a	bay roan
Vital Records, P.O. Box 68: ysician: The law requires that the death certifinition in sertificate has been signed by the attending director, page 2 should be detached for use as 1		Part II. Other significant cor	9 OHRIOWI	but not res	ulting in the ur	nderlying cause	given in Pa	art I.	23e. Did to	obacco use contrib	oute to the cause of death?
ires that the signed by	d b								1 Yes	2 No 3	Probably 4 🗸 Unknown
ords w requ as been should	Completed								24a. Was autop	sy pr	/ere autopsy findings available rior to completion of cause of
Rec The liftcate h	8						(5.4)		1 🗸 Yes		eath? ✓ Yes 2 No
Division of Vital Records, rat or Attending Physician: The law require rs after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be	o Be	25. Was case referred to med examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2 E	R/Outpatient			(Check on Nursing I	 	Residence 6	Other: Scene
n of \ding Phy	\vdash	27. Manner of Death	28a. Date of Inju (Month, Day,Y	ry 2 ear)	28b. Time of In		ury at Work	(? 28		how injury occurre	
Sior Attend r death ector: by the	Catio	2 Accident	ending vestigation 28e. Place of In	iury - At hom	ne farm street		Yes 2		Rf Location (S	Street and Number	r or Rural Route Number, City
Division spital or Attent ours after death seral Director: filled in by the	Certification:		ould not be etermined (Specify)	ury / 111011	10, 141111, 04100	, lactory, cilico	bullang, or		or Town, S		of Paral Rode Hamber, City
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of or examiner: On the basis of exam	knowledge	, death occurr	ed at the time, o	late and pla	ace, and du curred at t	ue to the caus	e(s) and manner a and place, and du	as stated. ue to the cause(s)
To wit	Me	29b. Signature and title of cer	and manaer stated.		`	29c. Licen					d (Month, Day, Year)
		M	-	21)	0.0	M.E.			October 3, 2	2012
0		30. Name and address of pers Russell Alexander N	A TOTAL TOTA			V. Baltimore	Street.	Baltimo	re, MD 21:	223	
	ate	31. Date filed (Month, Day,Ye									
Regist		961 1 7 20	1 Pleasers	1 A	arked					COME	
DHMH 17 Rev 1/20 OCME 2006	<i>)</i> U1				ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER T4 2012 STEPHEN HOLNIKER 07:04A M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1732 RIDGE ROAD WESTMINSTER CARROLL Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 213-68-0540 1 🛛 M 2 🗆 F 58 09/11/1954 MD Usual Residence of Decedent or 28a-f show 10c. City, Town or Location event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Tyes 2 X No MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1732 RIDGE ROAD 21158 USA "natural", or items and 2 should be filed within 72 hours after death Health and Mental Hygiene. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) **ENTREPRENEUR** GAMING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ KENNETH HOLNIKER **PEGGY** RIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other trong once. CAROLANNE HOLNIKER/WIFE 1732 RIDGE ROAD, WESTMINSTER, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH_TFILOH CONG. 10/17/2012 WOODLAWN, MD 21. Signature of uneral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause \ n each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of) 98760 Be Completed by Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box (3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown 5 Other (specify) Month Year Pregnant at time of death Day P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examina? 1 Yes 2 No ျ Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 \(\sime\) Yes Accident Suicide Investigation 2 No filled in by the within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I will be a stated of the death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 1)0051924 Name and address of person who completed cause of death (Item 23a) (Type, Print) MA 3973 Manchester RJ Manchester M 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-Unk Unk State of Maryland / Department of Health and Mental Hygiene 33357 2012 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day October 12, 2012 ShawNA 2235 hrs **Medical Examiner** 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Johns Hopkins Hospital Baltimore 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min Director Country) MD 18 219-41-1630 1 M 2 X F Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. Count 10c, City, Town or Location any 1 X Yes 2 No MD BALTIMORE 28a-f show . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene returns!", or items 23a or 28a-f she or and: If them 27 is marked other than "natural", or items 23a or 28a-f she or other tranmatic event, the Medical Examiner must be notified at once. Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? AVENUE USA 21218 ILCHESTER Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 2 X No Yes If Yes, Give Year 1 Yes 2 No specify: Specify: BLACK 3 Widowed 4 Divorced Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 STUDENT STUDENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last JONES Be JACQUETTA MAURICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19an Informant's Name/Relationship BAITIMORE, Md, 21218 427 ILCHESTER AVE. OTTER GrANdMother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, 1 Burial 2 Cremation 3 Removal from State 19/12 BATIMORE, MD MEMORIAL Donation 5 Other Specify 22. Name and Address of Facility VAUGHN GREENE FUNERAL SCVS permit. Signature of Funeral Service Licenses 4905 ROAD. BATIMORE, Md. 21212 Approximate Interval I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** ailure. List only one cause on each line Between Onset and Madical Death a. Gunshot Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✓ Unknown Unknown has been signed by the 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? Yes 2 No 2 No 1 🗸 Yes this certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 ✓ Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 1 🗸 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred 27. Manner of Death Certification: Oct 12, 2012 Subject shot Natura 1905 hrs 1 Yes 2 ✔ No Pending Director: after death. Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) 300 Blk. E. 26th St @ Guilford Ave., Baltimore, MD determined within 24 hours a (Specify) Sidewalk 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier October 13, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registraris Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

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AMEND TITEM# 2, 3perphys, 6933, 11714/2012, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **5**Day Month Mary-Agnes Jordan OCL 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Courtland Gardens Nursing & Rehab Ctr Pikesville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 □ M 2 1 F 85 217-24-2630 Apr 3 MD 1927 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes XX No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8638 Lucerne Road 21133 US 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3√DWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Home maker her home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Huber Angela Warmuth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Jordan 8638 Lucerne Road, Randallstown, MD daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Family Cemetery Oct 19, 2012 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service License 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road, Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) relà STANC her 6 Manle Due to (or as a consequence of) Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2000 Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Manner of heath 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hornicide

/Medical Examiner The law requires that the death certificate be executed Box 68760, the attending physician O. ئم Division or Vital Records, has Attending Physician: this s after deau.. al Director: After the filled in by the funeral 0

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Certifier

Funeral

Director

ortant; If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Dep. Imment of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event

Physician

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

5

To the Hospital within 24 hours at To the Funeral D 15 M

> State Registrar

29c. License number

1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and addres of person who completed cause of death (Item 23a) (Type, Print)

level BalliMare MD 21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAME 10 HN50~ OBERIS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Kandallstown Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Country) Director 1 M 2 F Yrs 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f Baltimore MI 1 Nes 2 No 10e. Street and Numbe 9 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2121 anier 12. Was Decedent Ever in U.S. Armer Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 þ 1 Never Married 2 Married Black, White, etc Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Blac "natural", If Yes, Give Completed 3 Widowed 4 Divorced ARMY Specify: Year or Dates. traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation UNK 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hygier other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ OTOSOX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If it
any injury or of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ FUERE CHRONIC OBSTRUCTIVE LUNG DISE disease or condition resulting in death) Medical Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events HYPERCARBIA Due to (or as a consequence of resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, MELLITUS Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ npatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No s after death I Director: A id in by the f Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N.W. HOSPITAL VIR. EDWATE OSAZEE

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G933, 11/27/2012, WS
State of Maryland / Department of Health and Mental Hygiene 20 2 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 14, Day 2012 DOLORES C. KINSEY 0855 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1905 NORMAN RD. ANNE ARUNDEL **GLEN BURNIE** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 246 505 7989 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2**XX** F Yrs 92 OCT 1, 1920 MD 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2xx No ANNE ARUNDEL **GLEN BURNIE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1905 NORMAN RD. 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Specify: WHITE 1 Yes 2 No Specify XX Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE W. REYNOLDS HAZEL V. KINSEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL MICHAEL SON 245 FRIENDS PLACE LN. FRIENDSVILLE, MD 21531 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State **GLEN HAVEN CEMETERY INC** 10.17.2012 GLEN BURNIE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lit FINK FUNERAL HOME, P.A. K. GREGORY FINK M01148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or hear only one cause on each line. Immediate Cause (Final Demention disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 🔀 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760 þ certificate has 24 hours after deaun.

• Funeral Director: After this of the funeral director in the funeral director.

Physician/

Medical

10a. State

MD

Director

Funeral

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Completed

Be

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Examiner

Funeral Director

or 28a-f shov

an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at

within 72 hours after death with the Maryland

permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event "to once."

Ph sician/

Medical

Examiner

Examine

Physician/Medical

by

IF FEMALE:

29b. Signature and title of certifier

Dominio

Maryland 21215-0036

Baltimore,

ted					1 🗆 Yes 2 🕽	1 Yes 2 🗷 No 3 🗆 Probabíy 4 🗆 Unknown	
Completed					24a. Was an autopsy performed? 1 □ Yes 2 ▶ No	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
၉	1 ☐ Yes 2 🕱 No	ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 \(\mathbb{N} \) Residence 6 Other (Specify)					
ertificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred	
O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						

State Registrar D50108 Gler Burne

Suil 200

29c. License number

10 15 2012

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

7845 Oakwood Road 32. Registrate Signature

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **OCTOBER** SIGRID H. LESLIE 11, 2012 0817 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORNINGSIDE HOUSE ANNE ARUNDEL FRIENDSHIP Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 214.76.5904 Min Director 15, 1936 76 **FEB GERMANY** 28a-f show 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director **ELKRIDGE** 1 Tes 2 XX No HOWARD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21075 5950 ELK FOREST CT. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Giv XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 🔭 No Specify: "natural" Completed 3XX Widowed 4 □ Divorced Specify: WHITE Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) **CUSTODIAN** AA CO SCHOOLS other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WILLY HERBERT GAITZSCH ALMA FRIEDA GOERMER and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 FRANK C. LESLIE SON 5950 ELK FOREST CT. ELKRIDGE, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State MDVETCEM CROWNSVILLE CROWNSVILLE, MD 4 Denation 5 Other (Spe 10.15.2012 22. Name and Address of Facility
FINK FUNERAL HOME, P.A.
426 CRAIN HWY SW CLEN BURNIE, MD 21061 GREGORY FIN M01148 f. Enter the disease, k, or heart lailure. Li 23a, Part emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart Interval Betweer Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed and Due to (or as a consequence of): ending physician are use as the burial Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 mon Ectopic pregnancy Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 R No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury in 24 hours after the Line Funeral Director: After the Funeral Director in Py the fur 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of lliot 32. Registrar's Signatu State

HMH 17 Rev 06-2011

Registrar

Box 68760

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 2012 Jovce Ann Lozado 10:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7250 Procopio Circle Columbia Howard 8. Date of Birth (Month, Day, Yo 3/24/1939 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🔽 F New York 73 Director 108-28-1279 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Fyaminas must have also in 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21046 7250 Procopio Circle 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 √ Yes 2 □ No Specify: Puerto Rican Specify: Puerto Rican 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) +2 Elementary/Seconday (0-12) Columbia Association Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Sutton Angelo Lozado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1914 County Rd., Apt. T3, District Heights, MD 20747 Samuel Brown / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/12/2012 Glen Burnie, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd., Columbia, 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Uniontrolled Ph, sician/ disease or condition resulting in death) Medical Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is it interests or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year cate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Tyes 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpa 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier To Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

3 🗌

29b. Signature and title of conti

4#1e

enite 202 colubri MD

29d. Date signed (Month, Day Year)
OCTOBER 10 TO 2012

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12-07789 Robin Leggett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 33363

00	1- For State Certificate of Death Reg. No.	0000
Physician/ Medical Examine	Robin Lunn Leagett Month Day Year 09	ne of Death 127 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign Country)	(State or
land fshow any once.	MD	nside City Limits
th the Maryland 23a or 28a-f sh notified at once	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2121 U.S. A.	
ter death with ", or items 23 er must be no		dian, Black,
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Reath and Mental Hygene. To ther traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	or Dates:	Care
-003(d within green. ther that	17. Father's Name (First, Middle, Last)	
21215-0036 total be filed within 7 d Mental Hygene. a marked other than it event, the Medical TO Be Comple	19a. Informant's Name/Relationship (Tro., Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or To., State, Zip Co.	ode)
e, MD I and 2 sho Health and item 27 is reaumati	20a. Method of Disposition (Name of cemetery, Date 20c. Location - City or fown,	10 19 D State
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Bygiene Important: If item 27 is marked other temportant or other traumatic event, the Mental Internation of the Internatio	1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee	1D
	Lunds Ine Ritter 5717 Green Past	
Physician Wedical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Asphyxia	roximate Interval veen Onset and Death
~ '	or condition resulting in death) Due to (or as a consequence of): Hanging Sequentially list conditions,	
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xecuted n and - transit		
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Division of To the Hospital or Attending Physitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification: T		
× × ≥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day O.C.M.E. October 15, 2012	/, Year)
6 perin	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	אר אווי לי די איזנגן (או די איזנגן אווי איזנגן אווי איזנגן אווי איזנגן אווי איזנגן אווי איזנגן אווי איזנגן אוו	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ cober 13 05054 eiter 2007 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ballimore Johns If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. **Director** 217-56-7817 1 🛛 M 2 🗌 F 60 12/08/1951 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 U.S.A. 419 N. Streeper Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. Specify. Completed 3 Widowed 4 X Divorced Year or Dates White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Industrial 12 Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) f Health and Mental H Item 27 is marked of Furmenek Robert Leiter Shirlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 419 N. Streeper St., Baltimore, MD 21224 Katrina Leiter / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 10/16/2012 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ a CENTE AZ NFRVOUS SYSTEM disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
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5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate Hospital or Attending Physician: Division of Vital completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 - No ၉ 1 Inpatient 2 R/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greans St. Balk more SARA JAL Registrar's Signatur State 7

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GREER Physician/ McMILLAN OCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 216-52-2688 Director 1 XM 2 - F MD 10/15/ 1948 Usual Residence of Decedent item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits death with the Meryland MD Baltimore 1 No Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral il Hyglene. other then "neturel", or items 23e HEATH FIELD 21239 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 ★ Yes 2 □ No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married 1 ☐ Yes 2 M No Specify. Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) US POSTAL SERVICE Elementary/Secondary (0-12) College (1-4 or 5+) etter CARRIGR 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) t. Pege 1 end 2 should be filed tment of Health end Mental Hi tent: If item 27 is marked ot McMILLAN SH UFFORD JOSEPHINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, MO. 21239 WIFE KOAD. ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date permit. Pege 1 e
Department of H
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eny Injury or ot 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State GARRISON FOREST 10/23/12 BACTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNCHAL SCUS Signature of Funeral Service License Bal ROAD. 4905 ALTO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freart failure. List only one cause on each line.

Immediate Couse (Final Approximate Interval Between Onset and Death Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner murcardia m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (as a consequence of): buriei-transi the Hospitel or Attending Physicien: The law requires that the death certificete be executed Due to (or as a consequence of): resulting in death) Last ettending physicien Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown for Day be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death,

To the Funerel Director: After this certificete has been si,
completely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death?

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		Please Type or Print				-	
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		Registrar 1. Decedent's Name (First, Middle, Last)	Certifica	ate of Death	Reg. 2. Date of Death	No. 20 2	33366
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Secretary of		Sinai Hospital of Baltim		Baltimore.		NA	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If Un Month	der 1 Year If Under 24 Hrs.	3. Date of Birth (Month, Day, Yea		hplace (State or Foreign intry)
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or item	by Fu	11. Marital Status 1 ☐ Never Married 2 Married 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No	n U.S. 13. Was Dec	cedent of Hispanic Origin? (Speci pecify Cuban, Mexican, Puerto Ri	y Yes or No- can, etc.)	14. Race - Amer Black, White	
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Mary 2 should 1th and Mi		19a. Informant's Name (Felationship (Type, Print)	19b. Mailing Addr	ess (Street and Number or Rural F	Route Number, City	or Town, State, Zip	and the same of th
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Baltimore, permit. Pege 1 and Depertment of Hea Importent: if item eny injury or other engine.	ı	21. Signa, re of Funeral Service Licensee		and Address of Facility 34/	With	antle	n J.F.
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Division of Vital Records, P.O. Box 68760 at or Attending Phyeicien: The law requires that the deeth certificate by a after death. In Director: After this certificate has been signed by the ettending physic and in by the funeral director, page 2 should be detached for use as the beautified.	5	g ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but no	t moulting in the underlyin	og course given in Deat I			
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physicien: The law requires that the death certificate be ewithin 24 hours after death. To the Funerel Director: After this certificate has been signed by the ettending physicien completely filled in by the funeral director, page 2 should be detached for use es the buri		29a. Certifier (Check 2 Medical Examiner: On the basis of examiner)	ation and/or investigation.	in my opinion, death occurred at the	time date and place	ce and due to the co	use(s) and manner etated
thin 2 the lathin 2 the lathin 2 the lathin 2		only one) 3 Certifying Nurse Practitioner: To the bes	t of my knowledge, death o	ccurred at the time, date and place	and due to the cau	se(s) and manner as	stated.
F \$ F 8		Adusumilli M.D	2	9c. License number D 73685		Date signed (Month, +000 v 9	

State Registrar

M.D., Sinai Hospital

of Baltimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sesha Adusumilli M.D., Sinai Hospita 31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 17 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0930 M Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) Country) Sourth Davs Hours Min. Director ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other treumatic event, the Ma Elementary/Secogdary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 1060NNELL မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or MNELL Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Burial 2 Cremation 3 Removal from State WINDSOR MILL 4 ☐ Donation 5 ☐ Other (Specify) MEMORI Signature of Funeral Service Licen 23a. Part LE fier the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final UER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events Examine Due to (or as a consequence of): use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Month Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been signe page 2 should be Records, 2 No 3 □ Probably 4 □ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, it **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of pertifier 205 who completed cause of death (Item 23a) (Type, Print) N. Charles 10 6

Registrar
DHMH 17 Rev 06-2011

State

Date filed (Month, Day, Year)

7

32. Regis

s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene ZU For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Physician/ Year 2105AM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 MM 2 D F Months Days Hours Min (Month, Day, Year) Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 N.No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Ro te Number, City or Town, State, Zip Code) 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, saltimore 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine Due to for as a consequence of: If any, leading to immedicause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-trar Due to (or as a consequence of): attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \text{ Yes} \) 2 \(\sum \text{ No} \) 24a. Was an cate has page 2 s autopsy certificate 2 No Be 25. Was case refer d to medical examiner? 26. Place of Death (Check only one) funeral director. Hospital: 2 🖾 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural Accident 5 Pending Investigation 24 hours after dear Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

1940 W. BALTIMURE ST. BALTIMURE, MD 21223

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANDHU

f () M ()
32. Registre s Sign

				Please	e Type or Pr amend State of M	int in B	lack In	delible fh. g9 artment d	Ink. E 32, 10 of Hea	nsure A -24-12 Ith and M	II Copie	es Are	e Legib e	le.	
		1	For State Registrar					tificate d				Reg. No	711	12	3336
F	Physiciar Medica	n/ al		th Neume	ister	_					2. Date of Domestin Month 10	eath 12	201 ^x	ear	. Time of Death 2:21 PM N
0	Examine	er		_	e street and number) e Medical	Œnte	r	4b. City, Tow Bel		ation of Death			c. County of Harfo		
	Funeral Director		5. Social Security N 213 -212-28-5	umber 6.		ge (In yrs. las	st birthday)	If Under 1 Y	ear If U	Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D	irth	9		e (State or Foreig
4			Usual Residence of	100	L	82	Yrs.	ation			12/25/	1929	1	Maryla	and Inside City Limits
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th the N	3a or 2 t be no	al Di	10e. Street and Nur	nber		-		10f. Zip Co					itizen of Wha	at Country?	
leath wi	ems 2	nue	6 South	Kelly A	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent		nic Origin? (Spe exican, Puerto	cify Yes or No			American I	ndian,
36 after o	o min	ক্র	1 Never Marr	ied 2 X Married 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	ХNо		Yes, specify			HICAN, etc.)		Black, Specify:	White, etc. White	ے
215-0036 in 72 hours after	"natur edical I	Completed	(Spe	15. Decedent's ecify only highest g	Education	ļ	(Give F	ent's Usual O	one during	g most of worki	ing		Kind of Busin	ness/Indust	ry
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	ed othe	To Be	17. Father's Name (18.	Mother's Name			Surname)		
Maryland 212 2 should be filed within	nd Mer s mark umatic	7	19a. Informant's Na		on Robinso		19b. Mailin	g Address (St		Loretta Number or Rura			or Town, Stat	e, Zip Code))
2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	of Health a fitem 27 is r other tra				ister, Sr		6 Sot	ith igh Kel	ly A	venue -	- Bel A	ir,	Maryla	and :	21014
<u> </u>		1			Removal from State	e ce	metery, cren	sition (Name of natory or other 1em _• Gdr	r place)		Date 7/2012		Location - Ci Air,		
Baltimore,	Department Important: I any injury o once,	1	21. Signature of Fu		**	Der	22	. Name and A	ddress of	Facility E.	F. Las	sahn	Fune:	ral H	ome, P.A
ш 8.0			23a Part 1. Enter t	the disease, or co	iplications that cause one cause on each li	ed the death.	. Do not ente	r the mode of	elair dying, su	Road -	- Kings or respiratory a	vill arrest,	e, Ma	Ap	21087
N	sician/ Medical aminer	8 8	shock, or hea Immediate Cause (disease or condition resulting in death)	(Final	a Drok	11-	- m	Jocan			facet				erval Between set and Death
2 executed	an and irial-transit	ical Examiner	Sequentially list co if only leading to fin cause. Enter Unde Cause (Disease or that initiated event resulting in death)	injury s	C	s a conseque									
Box 6876 death certificat	been signed by the attending physici should be detached for use as the bu		IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 9 ☐ Unknown	morths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	ı 2 ☐ Fetal at time of de	death 3] Ectopic preç] Other <i>(speci</i>					23d. Date Month		/ Year
S, P.O	gned oe de	2	Part II. Other signit	ficant conditions	contributing to death	but not resu	Ilting in the u	nderlying cau	se given ir	n Part I.					ause of death? y 4 🗹 Unknow
Records, P.O. The law requires that the	certificate has been lirector, page 2 shoul	Completed									per	s an opsy formed?	prid dea	or to comple ath?	findings available etion of cause of
Vital F	s certifica director, p	æ	25. Was case referr examiner?		Hospital:		/	2		of Death (Check		2 (28)	101		
of Vi	er this c	e: 10	27. Mann of Deat	Mo h	1 Inpa		28b. Time of	28c.	Injury at	☐ Nursing Ho	ome 5 Res 28d. Describe			(Specify)	
7	arter dearn. Director: After this d in by the funeral d	Certificate;	1 ✔ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	5 Pending Investigation 6 Could not determined	be 28e. Place of Ir		injury ne, farm, stre	М		2 🗆 No	28f. Location City or To			or Rural Ro	ıte Number,
7, O 🖺	urs illec	Medical C	29a. Certifier 1	☐ Medical Exar	ysician: To the best on the basis of the bas	examination	and/or invest	tigation, in my	opinion, de	eath occurred at	t the time, date	and plac	e, and due to	the cause(s) and manner sta
To the P	within 24 no To the Fune completely f	Me	only one) 3	Certifying Nu	rse Practitioner: To	the best of m	y knowledge	29c. Li	ed at the tir cense nun	ne, date and pla nber 7-2-2	ace, and due to	29d. D	se(s) and mar	Month, Day,	d. Year) Z012 1014
	5			ress of person who	completed cause of	death (Item :	23a) (Type, F	Print)	^6==	- A U.	. \	R-1	4	4D 7	1014
	Stat	e	31. Date filed (Mont	th, Day, Year)	32. Regis	trar's Signatu	ure L	pper	rnes	apeare	· UC,	1261	77.6	۷ (۱۰	4 - / (
	Registra	r	UUI	1 / 2012	Lever	p. ,	gare								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month \ O Kathleen Nichols 4.51 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A Examiner 4b. City, Town, or Location of Death MATIARMAS 4000 MOSPITH mD BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 214-62-8118 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Director 1 □ M 2**X**] F 10/25/1953 58 Maryland Itam 27 is merked other than "netural", or itema 23a or 28a-f shov othar traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A 1 Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3800 W. Belvedere Ave. Apt414 21215 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ğ 1 ☐ Yes 2 ☑ No If Yes, Give ltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) years Nurse Sinai Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Fred Barksdale Aline Jackson end r 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawarren Nichols (son) 2916 Ridgewood Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 e
Depertment of H
important: If its
any injury or ot Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Western Star 10/23/12 Baltimore, MD 21. Signature of Funeral Service License 30sepHdrs 好了Wn Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, PA MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPTIC disease or condition Medical resulting in death) Examiner INFECTION MARVIAN Sequentially list conditions, if ny saling to immach cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of or Attending Physician: The law requires that the deeth certificate be executed ettending physician end for use as the burial-trans Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes PNo
9 Unknown 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEPATITIS LIVER CIPPHOSIS 1 Yes 2 No 3 Probably 4 Unknown FAILURE ZENAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No Yes 2 🖵 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA arai Director: After this filled in by the funeral 27. Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD, BALTIMORE LOCH RAVEN SAMEEP SEHGAL 5601 31. Date filed (Month, Day, Year) Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

arry Uwem Etu	k N	1- For State	ate of Maryland		artment of rtificate of		nd Ment	al Hy	-	2	0 1	2 33	337
Physici	an/	Registrar 1. Decedent's Name (First, Midd			Timodic 4.			:	2. Date of Dea	eg. No. — th		3. Time of Death	
ledical Exami	iner		Etuk Navajo						Month October 7			1035 hrs	
		4a. Facility Name (if not institution NB Airpark Road Eas			4	b. City, Town, Gaithersb		f Death		4c. County Montgor			
Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Ye		r 24Hrs.		th(MM/DD/YYYY		place (State or	
Director		625-92-3962	1 M 2 F	54	Yrs.	Months Da	ays Hours	Min.	11/17/	1958	Cou	Nigera Nigeri	la
amy		Usual Residence of Decedent 10a, State 10b, County		10c. City	. Town or Location	on .						10d. Inside City	
Ĕ.,	Ŀ	CA LA		,	g Beach							1 Yes 2	
Maryland 28a-f sho 1 at once.	Director	10e. Street and Number				10f. Zip Code				0g. Citizen of Wh	nat Count	ry?	
MD 21215-0036 2 show the filed within 72 hours after death with the Maryland h and Montal Hygiener. 23 to marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once		1426 Pine Ave.				90813				Nigeria			
eath wi	Funeral	11. Marital Status 1 Never Married 2 MM	12. Was Decedent Armed Forces		.S. 13. Was	Decedent of H s, specify Cub	lispanic Origi an, Mexican,	in? (Spe Puerto F	cify Yes or No tican, etc.)	- 14. Race White		an Indian, Black	ζ,
after de	by Fu	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	₩ No	1	Yes 2XX N	lo specify:			Specify:	Blac	ck	
hours.		15. Decedent's Education (Spe			16a. Decedent during mo	s Usual Occup st of working li				16b. Kind of Bu	siness/In	dustry	
hin 72 e. than	Completed	Elementary/Secondary (0-12)	College (1-4 or	O+)	Sales					Self-er	mploy	<i>r</i> ed	
5-0C led wit Hygien other		17. Father's Name (First, Middle	,		ı					Maiden Surname)		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the Medical	o Be	Lawrence A. Etu 19a. Informant's Name/Relations	_		19h Mailing	Address (Sta			rison	nber, City or Tow	- Ctata	Zin Codo)	
MD 2 d 2 shou Ith and I n 27 is r	To	Maylene Etuk Na								Beach, (
re, restand freeze		20a. Method of Disposition 1 X Burial 2 Cremation	Removal from Str	ato.	Place of Disposit	er place)			Date	20c. Location -			
Baltimore, permit. Pages 1 at Department of He important: If ite		4 Donation 5 Other S	pecify:	Ros	e Hills		-)/2012	Whittie	•		
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumat.		21. Signature of Funeral Service		01452	Bai.	me and Addre	ss of Facility eral f	Iome	and Cr	emation orpe, M	Ser	zice, PA	A
Physician		23a. Part I. Enter the disease, or failure. List only one cause		the death	. Do not enter the	mode of dying	g, such as ca	rdiac or i	respiratory arre	est, shock, or hea	art	Approximate In	nterval
/Medical Examiner		Immediate Cause (Final disease	_{a.} Multiple Injuries					-				Between Onse Death	et and
		or condition resulting in death)	Due to (or as a conse	equence o	f):								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conse	equence o	f):								
t it	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence o	f):	·							
be executed ician and irial - transit	dical E	UNPENDED	d.	h Per	- FH C93	2 10/17	//2012	.TH		-			
60, ate be ex hysician te burial	Medi	IF FEMALE:	X AMENDED #19 #29b.per 23c. If yes, outcor			5-12' sī	1		-	23d. Date of	delivery		
OX 68760 eath certificate b attending physi for use as the bu	jan/	23b. Was decedent pregnant in the past 12 months?			2 Feta	death 3	Ectopic	pregnan	СУ	Month	Da	y Yea	ır
1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Physician/Me	1 Yes 2 No 9 Uni	9 Unknown		ath 5 Othe	er (Specify)							
ires that the d signed by the	by PI	Part II. Other significant condit	ions contributing to death	but not r	esulting in the un	derlying cause	given in Par	t I.		bacco use contri			
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of Vital Records, ing Physician: The law require the this certificate has been simeral director, page 2 should be	Completed				-				autop perfor	sy p med? d	rior to co leath?	npletion of caus	se of
il Rec n: The l rtificate or, page		25. Was case referred to medica	1			26.Plac	e of Death (Check on	1 Yes	2 No 1	✓ Yes	2 N	No
Vital bysician: this certifi	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatie	nt 2	ER/Outpatient		Othor -	-		Residence 6	Other:	Scene	
ding Ph	on: T	27. Manner of Death 1 Natural 5 Pend	28a. Date of Inju (Month, Day,Y oct 7, 2012	гу ear)	28b. Time of Ini 10:29 A	M	ury at Work? Yes 2 ✔ I	lo		now injury occurre auto auto col			
Division tal or Attendi rs after death. al Director: A	Certification:	2 Accident Inves	stigation 28e Place of In		ome, farm, street				8f. Location (S	street and Number	er or Rura	Route Number	r. Citv
Div oital or ours after eral Di	ert.		d not be		d / Highway	,	0.		or Town, S				
Division To the Rospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Sal		nysician: To the best of my miner:On the basis of exam										
To th withi To th	Medical	29b. Signature and title of certifie	and manner stated.	IIII ation a	nd/or investigation		se number	ured at t	rie tirie, date a	29d. Date signe			
		(06)	1 1 1	1	X		.M.E.			October 8,	•	, , , , , , , , , , , , , , , , , , , ,	
J M	ł	30. Name and address of person		•						L			
			Assistant Medical Ex			Iltimore Str	eet, Baltin	nore, N	/ID 21223				
St Regist	ate rar	31. Date filed (Month, Day Year)	12 32. Registra	s Signatu	barker	•							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2012 October | 7:50 A M Ernestine Della Noe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caroline Envoy of Denton Denton 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. (Month, Day, Year) September 3,1924 9. Birthplace (State or Foreign Country) + West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 💢 F 234-40-4830 88 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo Greensboro Maryland Caroline Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 21639 United States 25361 Calvert Dr. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 X No f Yes, Give Year or Dates: 1 ☐ Yes 2 X No þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) drug/pharmaceutical counter food store/grocery 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be flik ment of Health and Mental H tant: If Item 27 Is marked out Be Della Ferrell Ted Walls 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25361 Calvert Dr. Greensboro, MD 21639 19a. Informant's Name/Relationship (Type. Print) ent of Health a t: If Item 27 Is y or other trai Perry Noe/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department or Important: If any Injury or Dulaney Valley Mem GardOct. 17,2012 Timonium, Maryland 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Services of Dulaney 200 E. Padonia Rd. Timonium, MD 21093 Valley, THIMMUL Valley, P. t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on pach line. Immediate Cause (Final disease or condition Physician ARCINOMA HEPATOCEL disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ☐ Yes 2.VLNo 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural М 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

filed within 72 hours after

altimore, Maryland 21215-0036

ed by the a detached t Attending Physician;

State Registrar

29d. Date signed (Month, Day, Year)

D0053094

ATTENDING MIT

D 321 BLOOMINGDAKE JUE

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one)

29b. Signature and title of certifier

Thomas Vernon Newell, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2	0	ADDRESS OF THE PERSON NAMED IN	2	3	3	3	7	4

		- For State legistrar		Cer	tificate of	f Death		R	eg. No.	
Physiciar	n/	1. Decedent's Name (First, Midd	ecedent's Name (First, Middle,Last) 2. Date of Death Modify Day Yoar							
fledical Examin				WELL,				October 9	9, 2012	1552 nrs
1		4a. Facility Name (if not institution 7049 E. Baltimore Str	-	oer)		4b. City, Town, or Dundalk	r Location of [Death	4c. County o Baltimore	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ist birthday)	If Under 1 Yea			rth (MM/DD/YYYY)	Birthplace (State or Foreign
Director	_	165-68-1867 Usual Residence of Decedent	1 X M 2 F	33	Yrs	Months Day	/s Hours	Min. 03/11	<u>/1</u> 979	MARYLAND
any		10a. State 10b. County		10c. City,	Town or Locat	ion				10d. Inside City Limits
A	<u>.</u> [TIMORE	BA	ALTIMO					1 Yes 2 No
th the Maryland 23s or 28s-f sho notified at once.	Director	10e. Street and Number				10f. Zip Code		11	l0g. Citizen of What	at Country?
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th wit	= 1	11. Marital Status 1 Never Married 2 XM	12. Was Deced	es?		as Decedent of His es, specify Cubar		? (Specify Yes or No uerto Rican, etc.)	>- 14. Race - White	- American Indian, Black, , etc.
		_	orced If Yes, Give Year or Dates:	2 X No	1	Yes 2 X No	specify:		Specify:	WHITE
ours a		15. Decedent's Education (Spe		completed)		nt's Usual Occupa			16b. Kind of Bus	siness/Industry
5-0036 led within 72 hours afte rlygiene. other than "natural", the Medical Examine:	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	-	_	s. DO NOT us	se retired)		
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212 212 ald be Ments mark: even		19a. Informant's Name/Relations		, SR.	19b. Mailing	g Address (Stree	TAMI et and Numbe	MY DANI er or Rural Route Nur	nber, City or Town	n, State, Zip Code) 21224
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nor	- 1	1 Burial 2 Cremation 4 Donation 5 Other S		State	•		DRY	10/15/12	BALTIM	ORE, MARYLAND
Baltimore, pernit. Pages I an Department of He. Important: If ite injury ar ather tr		21. Signature of Expert Service		/				ER INC.		
E E S E		College !	100		1 /	00 5. (TUMO	TMG SIKE	CI,DALI	U., MD ZIZZ4
Physician	2	23a. Part I. Enter the disease, or failure. List only one cause		sed the death.	Do not enter ti	he mode of dying,	, such as card	diac or respiratory an	rest, shock, or hea	rt Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease				anyl Int	oxicat	tion		Death
-week		or condition resulting in death)	Due to (or as a co	onsequence of):					
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certification of the control of the	E I	past 12 months?	I Live birti	n it at time of dea	ath =	tal death 3 her (Specify)	Ectopic pi	regnancy	Month	Day Year
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P.O. ss that the gned by the detache		Part II. Other significant condit	ions contributing to d	eath but not re	sulting in the u	underlying cause	given in Part			oute to the cause of death?
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tal Recian: The certificate ector, page	en la	25. Was case referred to medica examiner?				26.Place		heck only one)		
Vit hysical this call dire	<u> </u>	1 ✓ Yes 2 No			ER/Outpatient			Nursing Home 5		
1 Of ling Ph After 1 funeral	ᇊ	27. Manner of Death 1 Natural 5 Report	28a. Date of (Month, D	ay Year)	28b. Time of I		ıry at Work?		how injury occurre	
Sior Attend r death ector: by the	Ĭ,	= J Pend	stigation		fd 00:0	оо ащ —	Yes 2 X N	medicat	e on pre	scription
Division of Vital Records, sapins or Attending Physician: The law requin hours after death. Ineral Director. After this certificate has been significant in by the funeral director, page 2 should the face of th	린		Id not be 28e. Place of (Specify)			et, factory, office te Rowhous	_	or Town, S	State) 7049 E	r or Rural Route Number, City Baltimore St.
a - = >	ल् ि	29a. Certifier 1 Certifying P	hysician: To the best of miner:On the basis of	examination ar				e, and due to the caus	se(s) and manner	
2 Min 2 000	Ž	29b. Signature and title of certifie	and manner stat er	<u>ea,</u>		29c. Licens	se number	-	29d. Date signe	d (Month, Day, Year)
^		Dann of Charth	all mi			O.C.	M.E.		October 11,	2012
14.4	3	30. Name and address of person	who completed cause	of death (Item	23a)	<u>_</u>			<u> </u>	
A Dark		Pamela E. Southall, N	100	edical Exar) W. Baltimor	e Street, E	Baltimore, MD 2	1223	
Star Registra		31. Date filed (Month, Day, Year)	2012	oran a Gigilatu	hay	4				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 16a-b, per fh, g932 10-17-12 sm
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death B. detaber inda Physician/ 9:00 PMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford <u>1414 Alexis Drive</u> Joppa Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min 1*0*%2074955 Maryland **Director** 56 220-62-3501 Usual Residence of Decedent shov or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 🛣 No Harford Joppa MD 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral U.S.A. 21085 1414 Alexis Drive and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural". or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Cosmetologist 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Cosmetic Industry Elementary/Seconday (0-12) College (1-4 or 5+) Cosmotic Industry Cosmebiogist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Bernice Neuhauser Linwood Parlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1500 Alexis Drive - Joppa, Maryland 21085 Wanda Lee Stevens (sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 【X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 10/15/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 in 1. Enter the insease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only he cause on each line. Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final nset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical LINUURecords, P.O. Box 68760 $^{\circ}$ IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year ☐ Pregnant at time of death☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 X No Certificate: To 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1XNatural injury 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of a year wholey and a country in the last of a year and out to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of a year and out to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of a year and out to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurs a Fraction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place are to the cause (s) and the ca (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0057256 10 and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore, MD 2123 filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2012 ΡМ October Ezekiel A. Oni Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Temple Hills Prince George's 4401 Birch Tree Lane 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 8. Date of Birth Funeral Hours Min. (Month, Day, Year) Director 233-19-8276
Usual Residence of Decedent 1 XM 2 - F 58 Aug. 1, 1954 Nigeria or 28a-f show notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland Director 1 X Yes 2 No Prince George's MD Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be n ō Funeral 20748 Nigeria 4401 Birch Tree Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after Specify: Black If Yes, Give Year or Dates 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Government 5+ <u>Case Manager</u> permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event, once. event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Unknown Timothy Oni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4401 Birch Tree Lane Temple Hills, MD 20748 Funmilayo Oni/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Lincoln Cemetery 10-27-2012 | Brentwood, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility J.B. Jenkins Funeral Home, Inc. Turk 7474 Landover Road, Hyattsville, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Metastatic Cancer of the Pancreas disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pt d for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the at Id be detached for 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has certificate Yes 21 N 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Affed in by the fur Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide within 24 hours after

To the Funeral Direct

completely filled in by determined

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

Date filed (Month, Day, Year)

<u>Jocelyne T. Kouatchou</u>

Jocelyne Kouakhou, mi)

82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

201 East University Pkwy Baltimore, MD 21218

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 2012 33376 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October **Physician** 15 2012 9:43P M Vibert Parris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner Hyattsville P.G. 2021 Patterson Street Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min 1 **X**M 2 □ F 78 5-9-34 Guyana Director 083-46-2015 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event. It is Martical Examines must have 10d Inside City Limits 10c. City, Town or Location 10a. State 10h. County Hyattsville P.G. XYes 2 □ No Director MD. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2021 Patterson Street 20782 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Force 1 Tes Torces: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Black þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Private Security Officer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Iris Trotman Hilbert Parris ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 19a. Informant's Name/Relationship (Type. Print) 187 Palmdale Drive, #7 Williamsville, NY Nolan Parris/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition **Burial 2 Cremation 3 Removal from State 10/23/12 Wash. DC 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cem. 22. Name and Address of Facility
Hackett's Funeral Chapel, 21. Signature of Funeral Service Licensi w. Hacked 814 Upshur Street, NW art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of) Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed Chronic Obstructive Pulmonary Disease sician and burial-trans Due to (or as a consequence of) 68760 Physician/Medical Anemia the attending p for use as t Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, been signe should be d þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Depression Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an Weight Loss as 2 autopsy performed? page 1 ☐ Yes 2X No certificate Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: / filled in by the fi 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number D45796

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of

Clayton 31. Date filed (Month, Day, Year)

Ŵ.

Straughn, M.D. 4404 Queensbury Rd. Riverdale,

20737

red cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 11 19a per inf 9932 10-31-12 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year HIUS 1012 0728 CT Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 0 Howard lumbia Ward 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 № M 2 □ F 3-16-1965 51-45-7663 Director Usual Residence of Decedent nit. Page 1 and 2 should e filed within 72 hours after death with the Maryland attrent of Health and Mental Hygiene. ortant: If item 27 is man ed other than 'natural", or items 23a or 28a-f show injury or other traumati event, the Me Teal Examiner must be notified at injury or other traumati event, the Me Teal Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No OWSON more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 US A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married ₩arried 2 No Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Blac 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) tandler Teria Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or any hele 100dsinto evou Uwinas 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State vant 10/UM big. 4 ☐ Donation 5 ☐ Other (Specify) (rematory, 10-22-2012 21. Signature of Funeral Service Licensee 22. Name and Address of acility aug In C. Greene Funeral services Vana 1/5 town, MO 21133 Kanda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MYSCALAIAL ARCTIA disease or condition resulting in death) ACUIE INF Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown ed by the a ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. b r signed b 23e. Did tobacco use contribute to the cause of death? ò TRICUSPI 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2/No မ 1 Inpatient 2 X ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 CT 5305 DA Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012ª Physician/ October 9:40 PM Nathaniel Moore Pigman, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Davs Hours (Month, Day, Year) Country) Director 1 XM 2 F 579-18-0462 92 February 29,1920 Washington 10d. Inside City Limits Department of Health and Mental Hygiene. Important; or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 21 so nutflied at one yill july or other traumatic event; the Medical Examinar must be nutflied at once. 10a. State 10b County 10c. City, Town or Location Director 1 Yes 2 x No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21044 U.S.A. 10101 Governer Warfield Parkway Apt 349 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Federal Government Statistician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Juliette Beland Nathaniel Moore Pigman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Maryland 21045 (Daughter) 5754 Thunder Hill Road Susan Pigman 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Glen Burnie, Maryland Atlantic Crematory 10-20-2012 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. Signature of Funeral Service Licensee 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FAILURE RESPIRATORY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) DMMUNITY tcourred that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No HOSPICE 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 eral Director: After this certificate has been signed by the atte filled in by the funeral director, page 2 should be detached for Division of Vital Records, 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature address of person who completed cause of death (Item 23a) (Type, Print) 6336 LANE CEDAR ABBBB MD 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 06-2011 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1 0 Month 3. Time of Death Physician/ Day 201°2 14 MARY ELIZABETH PARDOE 10:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1560 Curtis Ave Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours 03 12 1952 212 60 1166 60 Country) **Director** Yrs. MD Usual Residence of Decedent 28a-f show 10a. State notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Anne Arundel MD Glen Burnie 1 Yes 2 No 10e, Street and Number ò 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 1560 Curtis Ave 21060 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager Roto Rooter and Mental Hygie is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. John Lester Walker Gwendolyn Lavada Broyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, MD Arnold Pardoe - Husband 1560 Curtis Ave 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 10/16/12 | Baltimore, 21. Signature of theral x ruice Licensee 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122 23a. Part 17 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition END STAGE BREAST Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be Hospital: 1 Tes 2 X No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, hours after death. uneral Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 \square Pending injury filled in by the ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Hospital 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 29d. Date signed (Month, Day, Year) veully mo 00054739 16th 2012 donna OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 DAKWOOD 204 SUITE 2106 GLEN BURNIE MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

OCT

12-07662 Richard Plante

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Richard Plante		For State	State	of Maryland		artment of rtificate of		nd Mental H		eg. No. 201	2 3338
Physician	1.1	Decedent's Name	(First, Middle,La	st)	2.0				2. Date of Dea	ath Day Year	3. Time of Death
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	, ra.	Johns Hopki		TO OTTOO CATTO THAT TOO	• /		Baltimore			NI	A
Funeral	5. 5	Social Security N	umber 6. S	ex 7. A	ge (In yrs. I	ast birthday)	If Under 1 Y	ear If Under 24Hrs	_	rth (MM/DD/YYYY) 9. Bir Foreig	
Director	-	17-96-8		M 2 F		4QYrs	. IVIOTUIS DA	ays Flours IVIII	Sept		puntry) MI)
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21215-00 ould be filed wir d Mental Hygien s marked other tit event, the M		CI CI O	me/Relationship (Type, Print		19b. Mailing	Address (Str	reet and Number or	Rural Route Nur	mber, City or Town, State	e. Zip Code)
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G 84 B 5		a. Method of Disp				Place of Dispos crematory or oth		cemetery,	Date	20c. Location - City or	
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Division of Vital Records, P.O. Box 6876. ral or Attending Physician: The law requires that the death certificate its after death. al Director: After this certificate has been signed by the attending phyled in by the funeral director, page 2 should be detached for use as the transfer or the artification: To Be Completed by Physician/M.		rt II. Other signif	icant conditions	contributing to dea	ith but not re	esulting in the u	inderlying cause	e given in Part I.		obacco use contribute to s 2 No 3 Prot	
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Division of Vital Records, P.O. Box 6876 To the Boppital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the lawdical Certification: To Be Completed by Physician/M		10011 01119		r: On the basis of ex	amination a					se(s) and manner as state and place, and due to th	
To son	291	Signature and	title of certifier	and manner stated	l		29c. Lice	nse number		29d. Date signed (Mo.	nth, Day, Year)
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	30.	Name and addre		completed cause of fledical Examine	er 900	W. Baltimor	e Street, Ba	altimore, MD 21	1223		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Date of Death Physician/ binsor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1705 Sunny Court Woodlawn Baltimore If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 049-14-4485 (Month, Day, Year) Director 11-23-1925 86 Pennsylvania Usual Residence of Decedent irel", or items 23e or 28e-f show Examinar must be notified at 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Maryland Director 10d Inside City Limits MD 1 Yes 2 No Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1705 Sunny Court 21207 United States 12. Was Decedent Ever in U.S. Armed Forces? 1.07 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rces? 1942-Black, White, etc. þ 1 Never Married 2 Married 1XX Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced Specify: 1945 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Owner/Operator Gasoline Station permit. Pege 1 and 2 should be filed w Department of Heelth end Mental Hygi Importent: If item 27 is marked othe eny injury or other traumetic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emmanuel Albert Robinson Estella Mae Peck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth S. Robinson - wife 1705 Sunny Court, Woodlawn, Maryland 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Meadowridge Mem. Park! 10-15-2012 Elkridge, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ MMP. Inc, 7250 Wash. Blvd., Elkridge, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Therosclero Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ettending physician and I for use as the burial-transit Hospital or Attending Physicien: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the et ald be detached for 1 ∐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to predical æ 26. Place of Death (Check only one) examiner? ဂ္ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ame and address of person who completed cause of death (Item 23a) (Type, Print)

ADHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

7 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0010 AM 2012 SELMA RYND Dehober Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Ballimore Baltimore 01 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏅 F Months Hours Country) 0972371934 Director 117-26-4694 78 **GERMANY** Usual Residence of Decedent 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 Tes 2 X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8570 LEISURE HILL DRIVE 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 X Married 1 Yes 1 If Yes, Give Maryland 21215-0036 1 Yes 2X No Specify: 3 Divorced 4 Divorced Specify WHITE Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) VICE PRESIDENT HEALTH CARE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MAX BORITZER SONIA FAGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD RYND/HUSBAND 8570 LEISURE HILL DRIVE, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CEMETERY 10/14/2012 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Preumonitis Onset and Death Physician/ disease or condition resulting in death) Medical Due to for as a consequence of **Examiner** Assiration Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Epiglottic d
Due to (or as a donsequence of): dystunction Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Cel the attending physician and that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for in the past 12 months?
1 Yes 2 No Pregnant Pregnant at time of death 5 Other (specify) Month Day Year Unknown Part II., Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OPD Lower GI 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death. To the Funeral Director: After this certificate has I performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 ☐ Yes 2 X No HOSPICE ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

OCT

1 7 2012

Hospital of Baltimore, 2401W Belnedere Are,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Siner

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Filomena Silverman 2012 0058 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Bultimore Bultimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 115-05-8735 Director 1 □ M 2 🗓 F 95 12/27/1916 New York with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Pikesville 1 🗌 Yes 2 🎗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Slade Avenue Apt 422 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 2 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 X Widowed 4 ☐ Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Credit Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Salvatore Campanella Benedetta Mantione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Dockweller 7 Slade Avenue Apt 422 Pikesville, Maryland 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or 10/22/2012 St Raymonds Cemetery Bronx, New York 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee muchael 6009 Harford Road Baltimore, Maryland 21214 Marguel Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Septic to unrary truct infection disease or condition Snak Sacondaru Medical resulting in death) Due to (or as a consequence of) [']Examiner ostridum Unknaan Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) signed by the ettending physicien end d be deteched for use as the burlel-trensit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Hyportension 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physicien: The lew requires within 24 hours efter death.

To the Funerel Director: After this certificate has been sit completely filled in by the funerel director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes → No 24a. Was an autopsy performed Yes 2 To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 🗌 Yes 2 🗎 No 1 🗹 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISha 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#26perpHYS, G932, 10/17/2012, WS
State of Maryland / Department of Health and Mental Hygiene State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2012 4:55A 16. William James Santo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Director 57 MI 215-68-2497 1**X**□M2□F June 26, 1955 dence of Deced Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
It item 27 is marked other than "natural", or items 23a or 28a-f show lury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No Marriottsville Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21104 7070 Melstone Valley Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Computer Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dolores Regina Gunther William John Santo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7070 Melstone Valley Way, Marriottsville, MD 21104 Christina M. Santo (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 XCremation 3 Removal from State All County Cremation 10/1/72012Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA Blian L. Hava M00764 PO Box 195 Sykesyille. 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final METAMATIC BLADDER CANCER Physician IYEAN disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to for as a consequence of: Exami attending physician and I for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) signed by the at Id be detached for ☐ Yes 2 ☐ No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? ğ Division of Vital Records, 2 🗹 No 3 Probably 4 Unknown 1 Tyes should Completed 24b. Were autopsy findings available 24a. Was an this certificate has I prior to completion of cause of death?

1 Yes 2 No autopsy performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Presidence 6 1 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manne of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and title of certifi 10/16/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ORLEANS ST. IMSIBALLHONE, TD 2173/ E. SKURKERGKH MARIO 1650 A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Smith 2012 Robert 9:01 AM John October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3132 Adderley Court Montgomery Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 GM 2 GF Months Days Hours Min. 'eb 18, 1 Maryland 578-22-9995 87 Director Feb Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director 1 Yes 2 No Silver Spring MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö er than "natural", or items 23a on the Medical Examiner must be 20906 Funeral 3132 Adderley Court USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Je filed with:

→al Hygiene.

→ar than "r Elementary/Seconday (0-12) College (1-4 or 5+) Banking Security Officer permit. Page 1 and 2 should be filed wit Department of Heath and Mental Hygiel Important: If item 27 is marked other 1 any injury or other traumatic event. th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Ida Mae Rohman John A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Aniceta Smith -3132 Adderley Court Silver Spring, MD Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Rices Landing, PA 10/16/12 4 ☐ Conation 5 ☐ Other (Specify) Hewitt Cemetery Metropolitan Funeral Service 21. Signature of Fu eral Service License 22. Name and Address of Facility Alexandria, VA 22310 5517 Vine Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 years Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin nding physician and use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 $^{\sim}$ Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Other (specify) Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has performed?

1 Yes 2 No 1 ☐ Yes 2 🛣 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 \(\text{\text{Nursing Home}}\) 1 \(\text{Nursing Home}\) 2 \(\text{\text{Residence}}\) 6 \(\text{\text{\text{Other}}}\) Other (Specify) 2 K No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred injury 5 Pending 1X Natural 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral

Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FERKUS

(Check only one) determined

October 15,2012

State Registrar

🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2012 Oct. Wilma Lee Stancil 15, 1:20 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 8. Date of Birth Hours Min (Month, Day, Year) 244-28-9727 Director 1 □ M 2 🖁 F 88 North Carolina Jan. 2, 1924 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must ha notified a 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland| 1X Yes 2 ☐ No Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6500 Riggs Road 20783 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Alston Estelle Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lonnie Owens (Son) 2461 Gately Dr. W. West Palm Beach, FL 33415 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 2 🖺 Cremation 3 🗌 Removal from State cemetery, crematory or other place) Oonation 5 C Other (Specify) Metropolitan Crematory 10/17/12 Alexandria, VA 21. Signature of Juneral Service Livense Metroporitaficiruneral Service 5517 Vine St., Alexandria, VA 22310 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIAL Ph sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ENSION burial-tran that initiated events Division of Vital Records, P.O. Box 68760 🦟 resulting in death) Last PHEUMONIA Physician/Medical IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death Year 1 Yes 2 B 9 Unknown ed by the a detached i signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? page 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 🗶 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No မ Other: 24 hours after death. Funeral Director: After this 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate; 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 X Natural work Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hound to the second 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar ess of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

HAMOVERPARKWAY GREENBELT MARYLAND 20770

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Phys M Exa To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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hysicia	ın/	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death	
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	mandine		Name and Address	s of Facility	y J. B	. Jenki	ns Fun	eral 1	Home, Inc.	
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tor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	lace of Injury - At home,	form stro		Yes 2 🗆		206 Lanation /C	tue et eu el Alcue	hana Dum	J. Bauta Mumban	
I Direct			uilding, etc. (Specify)	iaiii, siree	st, lactory, office		ľ	City or Town		ber or nura	l Route Number,	
To the Funeral Director: completed filled in by the	Medical	29a. Certifier 1 Certifying Physician: To to (Check 2 Medical Examiner: On the										
o the l	Me	only one) 3 Certifying Nurse Praction 29b. Signature and title of certifier				time, date		e, and due to the		manner as st	tated.	
24		1 Mayou	Mou	0	RI	12	150	K	10/5	3/12	7	
nic.		30. Name and address of person who completed					امر	01	. 6	111	00 0 00 00	
Stat		31. Date filed (Month, Day, Year)	2. Registrar's Signature	2 Ch	arlotte	Hal	Ro	Char	det	10th	WD 90933	
ວເລເ legistra		OCT 1 7 2012	un B. d	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Derbosely 8 2012 10.19 P M DAVID JAY SWEITZER Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ANNE SALTIMORE WASHINGTON MEDICAL CIEN MENIE Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours 212 54 8836 Director 1 X M 2 □ F 15 1950 62 08 Maryland Usual Residence of Decedent 10b. County the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director . Page 1 and 2 should be filed within 72 hours after death with the Marylar ment of Health and Mental Hygiene. It it item 27 is marked other than "natural", or Items 23a or 28a-f si lury or other traumatic event, I'm Medical Examiner must be notified. MI) Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 724 211th ST 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1970 Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryĺand 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 1973 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) Drywall Mechanic Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frances Geraldine Jay Sweitzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any Injury or other tr Doris Sweitzer - Wife 724 211th St Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Payview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 10/10/12 Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CJ Gonce Funeral Home Drive Pasadena, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy 5 Other (specify) Month Day Year g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Ves 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? မ 1 Tes 2 🖪 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide To the Hospital or Atter within 24 hours after der To the Funeral Director completely filled in by th 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) drive 31. Date filed (Month, Day, Yea)

QCT 1 7 201 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Mar			ealth and Mental I	Hygien	ie	
			Registrar 1. Decedent's Name (First, Middle, Last)	·· ·	rtificate of De	2. Date of	Reg. N	No. 201	2,3338
	Physicia Medic		Cicely Gen	aldine	Tuckt	~	Month 10	15	Year ZOI	2 1:03 A M
	Examir	er	4a. Facility Name (if not institution, give s The Dove House	street and number)		4b. City, Town, or Lo			c. County of Dea	ath
	Funeral Director		==: 00 00),	777	yrs. last birthday) 39 Yrs.		If Under 24 Hrs. 8. Date of (Month)	Birth Day, Year 3/192) Ca	inthplace (State or Foreign ountry)
	show	١	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or Lo	cation				10d. Inside City Limits
	28a-f	irect	Maryland Carroll		Westmins	ter				1 XYes 2 □ No
4	is 23a or nust be n	Funeral Director	10e. Street and Number 505 High Acre Dr	ive		10f. Zip Code 21157			Citizen of What C	ountry?
0036	populations of the latter and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 【▼ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates.		If Yes, specify Cuban, I	anic Origin? (Specify Yes or I Mexican, Puerto Rican, etc.) Specify:	lo-	14. Race - Ame Black, Whit	
1215-(than "nat than "nat he Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)	ucation de completed) College (1-4 or 5+)	(Give life. L	dent's Usual Occupation kind of work done during O NOT use retired)	on ing most of working		Kind of Business	i
Maryland 21215-0036	lental Hygis rked other tic event, ti	l as l-	12 17. Father's Name (First, Middle, Last) Gerald Nichols		Admi	nistrator 18	8. Mother's Name (First, Midd Cicely Russe	lle, Maider	rsing Ho	one
, Mary	aalth and M n 27 is ma er traumat	9	19a. Informant's Name/Relationship (Type Claudia Feasel	Daughter	19b. Maili 335	ng Address (Street and North Town)	Number or Rural Route Num ship Road 165	ber, City o	or Town, State, Zi fin, Ohi	ip Code) .o 44883
Baltimore,	tment of He tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Center o	ntory or other place) f Maryland		Har	Location - City or	laryland
Ball	Depart Impor any in		21. Signature of Funeral Service License	mallo-		6009 Harfo	of Facility Marzullo rd Road Balti	more,	eral Cha , Maryla	pel, P.A. and 21214
Ph	sician/ Medical		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line. Due to (or as a cor	ud	er the mode of dying, s	uch as cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
E	xaminer	Jer	Sequentially list conditions,	Due to (or as a cor						
scuted	and -transit	xamir	if any, leading to immediate cause. Enter Unidentifying Cause (Disease or imjury that initiated events resulting in death) Last	Due to (or as a cor						
760 icate be executed	physician the burial	edical Examiner	resulting in death, cast	i	isequerice (i).					
. Box 687		Σ∣ι	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pr 1 Live Birth 2 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		-	23d. Date of del Month	livery Day Year
ds, P.O.	en signed by	בׁ בַ	Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause given i				the cause of death?
Il Record In: The law rec	nis certificate has bee I director, page 2 sho	e Completed	5. Was case referred to medical			00 81	pe 1 □ Ye	as an copsy formed?	prior to death?	topsy findings available completion of cause of
Division of Vital Records, alor Attending Physician: The law requires	ith. : After this cert s funeral direct	10 B	examiner?	ospital: 1 Inpatient : 28a. Date of injury (Month, Day, Yea	2 ER/Outpatien 28b. Time of injury	DOA Other: 4 28c. Injury at work?	of Death (Check only one) 1 Nursing Home 5 Re 28d. Describe			IN PATIENT FUELDE
Divisio	s after des	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre ecify)		28f. Location	(Street an own, State	d Number or Rur)	ral Route Number,
the Hospit	thin 24 hou the Funer: mpleted fills	Med	only one) Medical Examine Certifying Nurse	er: On the basis of examin	nation and/or invest	gation, in my opinion, de	te and place, and due to the eath occurred at the time, date ne, date and place, and due to	and place	and due to the c	cause(s) and manner stated
P	7 ⊗		9b. Signature and title of certifier	Vante	nun	29c. License nur D 35	398	29d. Da	te signed (Month	, pay, Year)
5			0. Name and address of person who cor PAVIO KRUTER 1. Date filed (Month, Day, Year)	ndleted cause of death ((Item 23a) (Type, P	inst. We	stminister	M	21/5	7
	State Registra		OCT 1 7 201	2 Appene	B. pa	Mad				
A DHWH	17 Rev 7/200	g								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARMEN 4:40 October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3018 Ellicott Hills Blvd. Ellicott City Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 M 2 X F Min February 22 Hours 230-58-5426 **Director** 69 Virginia Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10h. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits Maryland Howard 1 Yes 2 No Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3018 Ellicott Hills Blvd. 21043 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify: Completed 3 Divorced Specify. Year or Dates Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the I Psychologist Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Turpin, II Rachel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Beebe (husband) 3018 Ellicott Hills Blvd. Ellicott City, Maryland 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place) Atlantic Crematory 10-20-2012 4 Donation 5 Other (Specify) Glen Burnie, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ardio pulmos My Holden Medical Examiner Cars Esquantially list so ultions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examir sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Matural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760 Division of Vital within 24 hours

To the Funeral

State Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and title of

ORIGINAL

11055

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Little PATUXCON Porke

22856

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 3339 I 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobe Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Balteriose Washington Burnie Medical Center Glen Runde Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 216-35-8943 **Director** 1 □ M 💥 F 20 11/7/1991 Baltimore, MD Usual Residence of Dec show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It was a 28 or 10a, State items 23a or 28a-f sho ier must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 298 Scotts Glen 21061 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes XX No If Yes, Give Black, White, etc. 1XX Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: 3 Divorced Specify: White Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Student Dependent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert L. Thing, Jr. Jayne D. Love11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Father 298 Scotts Glen Mr. Robert L. Thing, Jr. Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I-Important: If ite any injury or ot 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit, Page cemetery, crematory or other place) Meadowridge Mem. Park 10/19/2012 Elkridge, MD ice Lic Fur eral S 22. Name and Address of Facility Singleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disea nock, or heart failure. Lis Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Monia Medical **Examiner** Sequentially list run iti. no Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day 1 Yes 2 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 2 2 N 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) K Natural 5 Pending 1 Yes 2 No Accident Investigation ☐ Acciden
☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the based of my knowledge only one 29b. Signature and tit of person who completed cause of death (Item 23a) (Type, Print) BURE WO

State

Registrar

31. Date filed (Month, Day, Year)

7 2012

32. Registar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Registrar 1. Decedent's Name (First Middle 1 ast) 2. Date of Death Physician/ Month Ethel Reita Trocher October 6:52 Medical 2012 a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Months Hours (Month, Day, Year) 435-22-9091 Director 88 1 □ M 2 🖾 F 03/10/1924 Louisiana permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f shove way injury or other treumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Ellicott City Howard 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 2918 Excelsior Springs Court 21042 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 Z No Specify 3 🖾 Widowed 4 🗆 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Cambre Lillie Edmonston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Trocher - son 2918 Excelsior Springs Ct. Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baker, Louisiana Hillcrest Mem.Gardens: 10/20/2012 21. Signature of Funeral Service to 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition resulting in death) TANCOLITIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): pate has been signed by the ettending physiclan end page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ COPD-CHRONIC OBSTRUCTIVE PULMONARY Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown DEMENTUA 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completely filled in by the funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No မှ HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of gertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ABBAS 6336 COLUMBIA, MD Q LANE CEDAR

Registrar

31. Date filed (Month, Day, Year)

OCT 1 7 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Charles Taylor 2012 October Medical 2:05 P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Stella Maris Hospice</u> Timonium Baltimore If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 213-36-9022 1 🛛 M 2 🗆 F Yrs. 74 07/15/1938 Maryland 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD Baltimore Perry Hall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4503 Dunton Terrace, Unit D 21128 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 3 1 X Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", 1 ☐ Yes 2 X No Specify. Completed 3 Divorced 4 Divorced If Yes, Give Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cashier Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Richard Taylor Mary Ruth Wanner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gloria Porta / Sister</u> 4503 Dunton Terrace, Unit D, Perry Hall, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 10/16/2012 | Hanover, Maryland 21. Signatur of Funer Cervice Lice 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death OLUN disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the accompletely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 📉 No 3 🗆 Probably 4 🗆 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? 2 🗆 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specific Section) 2 X No 욘 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the final date and plane, and due to the name and manner as clated only one 29b. Signature and title ed cause of death (Item 23a) (Type, Print) 2300 DULAN

State Registrar Mark Aaron Thompson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2012 33394

		Itegisuai	ate of Death	Reg.	No.				
Physic ledical Exam		Mark Aaron Thompson		2. Date of Death	3. Time of Death				
)		Facility Name (if not institution, give street and number) 7379 Baltimore Annapolis Blvd	4b. City, Town, or Location of De Ferndale	eath	4c. County of Death Anne Arundel				
Funera Director		218-90-0453	January, Jan						
Maryland 28a-f show any d at once.	Director	Usual Residence of Decedent 10a. State	or Location Limore 10f. Zip Code	10g.	10d. Inside City Limits 1 Yes 2 No Citizen of What Country?				
death with the Maryland or items 23a or 28a-f sho must be notified at once.	a Dire		21215		USA				
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Inportant: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	À	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue Yes 2 No specify:	erto Rican, etc.)	14. Race - American Indian, Black, White, etc. White Specify:				
0036 within 72 hour iene. cer than "natu	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 1 2	ecedent's Usual Occupation (Give kind uring most of working life. DO NOT use cicklayer	retired)	b. Kind of Business/Industry Construction				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be Co		unk	me (First, Middle, Maid	unk				
MD 2 nd 2 shou alth and N	F	Sharon A Thompson Wife 50	Mailing Address (Street and Number of 18 E Sycamore S	St Evansv	ille IN 47715				
Saltimore, permit. Pages 1 ar Department of Hee mportant: If ite		1 Burial 2 X Cremation 3 Removal from State cremator)/13/12	Crom Fun Sorv				
Physician	Ц	23a. Part I. Enter the disease, or complications that caused the death. Do not			Crem & Fun Serv ge Rd Hanover MD				
/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Athe Due to (or as a consequence of):			Between Onset and				
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated							
cecuted and ransit		events resulting in death) Last Due to (or as a consequence of):							
1760, ficate be exe g physician a	/Medical	IF FEMALE: AMENDED 23a, 27, per m 23c. If yes, outcome of pregnancy	ne,g933 11-1-12 sm	-	23d. Date of delivery				
Box 687 The death certification is the attending property and the for use as the form is	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5 g Unknown	Fetal death 3 Ectopic preg Other (Specify)	nancy	Month Day Year				
s, P.O.	þ	Part II. Other significant conditions contributing to death but not resulting it	n the underlying cause given in Part I.		co use contribute to the cause of death? No 3 Probably 4 V Unknown				
Records The law requires to the law requirements been least been page 2 should	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No				
Vital ysician: his certi director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	26.Place of Death (Checo		dence 6 Other; Scene				
Division of value of a or Attending Phers after death. al Director: After it led in by the funeral	ation: T		ne of Injury 28c. Injury at Work?	28d. Describe how i	njury occurred				
Division A cours after peral Dire filled in b	Certification:	4 Homicide determined (Specify)	n, street, factory, office building, etc.	28f. Location (Stree or Town, State)	t and Number or Rural Route Number, City				
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	occurred at the time, date and place, are estigation, in my opinion, death occurred	nd due to the cause(s) I at the time, date and p	and manner as stated. blace, and due to the cause(s)				
	Σ	29b. Signature and title of certifier Theodore W. K. & Th. Mu	29c. License number O.C.M.E. 06M		d. Date signed (Month, Day, Year) Ctober 6, 2012				
)Ø		30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examina	er 900 W. Baltimore Street,	Baltimore, MD 21	223				
St Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	***						
HMH 17 Rev 1/20	001	ORIG	SINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene
			Registrar Certificate of Death Reg. No. 2012 3339.
	Physicia Medi		JOSEPH S. TURCHETTA 10 14 Day 2012 5:00 P M
	Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
	Funeral		Baltimore Washington Medical Cr Glen Burnie Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		193 14 6958 1 M 2 D F 89 Yrs. Months Days Hours Min. (Month, Day, Year) Country)
	ind show at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Maryla 18a-f tified	Funeral Director	MD Anne Arundel Pasadena 1 □ Yes 2 🔀 No
	h the l	je je	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	ath wit ms 23 must	ner	771 221st St. 21122 U.S.A.
9	er dea or ite miner	by F	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 1946 1 ☐ Yes 2 🗷 No Specify: Specify: White
15-	72 ho n "nat fedica	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working) 16b. Kind of Business/Industry
212	within giene. er tha		Elementary/Secondary (0-12) College (1-4 or 5+) life. DO NOT use retired) 10 U.S. National Security Agency
	filed al Hy d oth	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Maryland			Serafino Turchetta Maria Vincenza Testa
	12 shou ath and 27 is m r traum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Turchetta – Wife 771 221st St. Pasadena, MD 21122
ore,	ye 1 and 2 should be t of Health and Men If item 27 is marke or other traumatic		20a. Method of Disposition Comparison C
Baltimore,	Page tment c tant: If jury or		4 Donation 5 Other (Specify) Glen Haven Mem Pk 10/18/12 Glen Burnie, MD
Bal	permit. Pag Departmen Important: any injury once.		21. Signature of Euner 22. Name and Address of Facility GJ Gonce Funeral Home, PA 169 Riviera Drive Pasadena, MD 21122
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
).	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) Onset and Death
	Examiner		Due to (or as a consequence of):
	T	iner	Se guentially list conditions if any, leading to immediate cause. Enter Underlying
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to for as a consequence of:
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9289	tificate ng phy as th	Med	IF FEMALE:
9 x c	eath certifice attending p I for use as i	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery
Box	he des y the a	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown
P.O.	s that t gned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
rds,	een sig		1 Yes 2 No 3 Probably 4 Unknown
Records,	The law nate has b	Completed	24a. Was an autopsy autopsy findings available prior to completion of cause of
Ě	in: The ificate or, pa _e		performed → death? 25. Was case referred to medical 1 Yes 2 No 1 Yes 2 No
Vita	ysicia is cert direct	To Be	26. Place of Death (Check only one) Check only one Check only one
o	ing Ph		27. Manner of Death 1
sion	ttendi death tor: A y the f	Certificate:	2 Accident Investigation M 1 Yes 2 No
Division of Vital	ital or A irs after ral Direc lled in by		4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 heard ster death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 29 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Vortice Con		29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/15/12
L (30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
1	Stat		A. SHAMS, M.D. 716 MAIDEN CHOICE LN Ste 301 Baltimore, MD 21228 31. Date filed (Month, Day, Year) 32. Degistrar's Signature
	Registra	-	OCT 1 7 2012 Januar S. Sare
DIMA	H 17 Rev 06-2		

Registrar

7 2012

PAUL WIEGEL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 3339 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Cert	ificate of	Death			Re	eg. No.		
Physici		Decedent's Name (First, Middle)		-				2.	Date of Deat	h		3. Time of Death
Medical Exam	iner	Lorenzo Edw	vard White	e					Month October 1	Day Year 0, 2012		1551 hrs
-		4a. Facility Name (if not institutio		oer)	. 4	lb. City, Town, or	Location o	of Death		4c. County of		
		Franklin Square Hosp	ital			Rosedale				Baltimore	Cour	nty
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. las	t birthday)	If Under 1 Yea	_		8. Date of Birt	th(MM/DD/YYYY)		
Director		218-43-4073	1X M 2 F		17 Yrs.	Months Day	s Hours	Min.	03/2	1/1995	Foreign Cou	ntry) MD
1		Usual Residence of Decedent										
7 any		10a. State 10b. County		10c. City, T	own or Location	on						10d. Inside City Limits
aryland 8a-f show	5	MD Balti	more Co.		Nott:	ingham						1 Yes 2 No
faryli 188-f	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wha	at Count	ry?
hours after death with the Maryland natural", or items 23a nr 28a-f sho Examiner must be notified at once.		31 Lerner Ct	•			21236	5			U.S	Δ	
with with 23 pe 100	2	11. Marital Status	12. Was Deced		13. Was	Decedent of His		in? (Speci	fy Yes or No-			an Indian, Black,
death r iten	Funer	1 X Never Married 2 Ma	Armed Force	es? 2 X No	lf Y∈	es, specify Cubar	n, Mexican,	Puerto Ric	an, etc.)	White,	etc.	
ifter Il", o	by F	3 Widowed 4 Div	orced If Yes, Give Year or Dates:	- 🔼 140	1 🔲	Yes 2 X No	specify:			Specify:	В	lack
ours a		15. Decedent's Education (Spec	ify only highest grade	completed) 1		's Usual Occupat				16b. Kind of Busi	iness/In	dustry
2 2	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	auring mo	st of working life.	. DO NOT	use retired)			
within 72 giene.	Ē	11th Grade			St	udent				N/A		
5-00 led wit Hygien the M		17. Father's Name (First, Middle,	Last)				18.Mother	s Name (Fi	rst, Middle, M	laiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	Paul White					Jea	nett	e Wil	liams		
hould Me	To	19a. Informant's Name/Relationsh			19b. Mailing	Address (Stree	t and Num	ber or Rura	al Route Num	ber, City or Town,	State, 2	Zip Code)
and 2 should be fi lealth and Mental tem 27 is marked traumatic event,		Paul A. Whit	e(Father)		2524	Hallam	Ct.	, Wi	ndsor	Mill,	MD	21244
re, N s 1 and f Healtl lf item	T)	20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	State 20b. Pla	ce of Disposit matory or other	ion (Name of cer er place)	metery,	D	ate	20c. Location - C	City or To	own, State
imore Pages 1 nent of H tant: If i		4 Donation 5 Other Sp	_		Zion	cem.		10/2	6/12	Baltir	nore	e. MD
my parti	-11	21. Signature of Funeral Service		11.	22-N	and Address	of Eacility	wn T	r Fu	noral I	Iom	DA
E E B M	, le	a which	N. Will	llam	21 21	40°N."	Füİt	on A	ve.,	Baltimo	ore,	PA , MD21217
Physician		23a. Part I. Enter the disease, or a failure. List only one cause of	complications that caus	ed the death. D	o not enter the	e mode of dying,	such as ca	rdiac or re	spiratory arre	st, shock, or hear		Approximate Interval
/Medical Examiner	М	Immediate Cause (Final disease	a Ruptured	Aortic	Media	Dissec	tion				Ī	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co		neara	DISSEC	LIOH				_	
of special		Sequentially list conditions,	b									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cor	nsequence of):								
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760, ficate be g physic the burn	/Mec	IF FEMALE:	23c. If yes, outc	come of pregnar	ncv				·	23d. Date of de	elivery	
587 ertific fing p	an/	23b. Was decedent pregnant in the past 12 months?	I I I LIVE DITTI		2 Feta	I death 3	Ectopic	pregnancy		Month	Da	y Year
Box 687 re death certifuthe attending red for use as t	Sici	1 Yes 2 No 9 Unkr	20140	at time of death	5 Othe	er (Specify)						
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res that the signed by	ğ	Part II. Other significant condition	ins contributing to de	ath but not resu	liting in the un	derlying cause gi	iven in Pari	t.I.		acco use contribu		
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cords law requi	흺	·							24a. Was ar autops			osy findings available appletion of cause of
Pec The lar ate ha	Completed								perform 1 Yes 2		ath? Yes	2 No
Vital Rec ysician: The his certificate	BeC	25. Was case referred to medical	Т			26.Place	of Death (C	Check only				
Vita ysici his ca direc	0	examiner?	Hospital: 1 Inpa	itient 2 🗸 EF	VOutpatient	3 🔲 DOA	Other ₄	Nursing Ho	ome 5 R	esidence 6	Other:	
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been side in by the funeral director, page 2 should be		27. Manner of Death	28a. Date of Ir (Month, Day	njury 28	Bb. Time of Inju	ury 28c. Injun	y at Work?	280	. Describe ho	w injury occurred		
ion tendii eath.	흹	1 X Natural 5 Pendii	ng	,, real)		1 🗆 Y	es 2 🔲 M	No				
ViSi or Att fter de Direct in by	<u></u>		igation 28e. Place of	Injury - At home	e, farm, street.	factory, office bu	uilding, etc.	28f.	Location (St	reet and Number	or Rural	Route Number, City
Dispital cours at filled i	Certification:	4 Homicide determ							or Town, Sta	ite)		
Divis Hospital or A 24 hours after Funcral Dire		29a. Certifier 1 Certifying Phy	ysician: To the best of	my knowledge,	death occurre	d at the time, dat	te and plac	e, and due	to the cause	(s) and manner as	stated.	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Medical	one) 2 Medical Exam	iner:On the basis of ex and manner state	kamination and/	or investigatio	n, in my opinion,	death occu	urred at the	time, date ar	nd place, and due	to the c	ause(s)
F 3 F 3	Σ	29b. Signature and title of certifier	gara marmer state	4		29c. License	number			29d. Date signed	(Month	, Day, Year)
,		his hu	~			O.C.N	Λ.E.			October 11, 2	2012	
1	t	30. Name and address of person w	vho completed cause of	f death (Item 23	a)			_			_	
N			t Medical Examin		•	Street, Baltin	more, M	D 21223	3			
Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	,							
Regist	rar	UUT 1 7 2012	Coner	1. 1	Jacker	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Frederick Wagner Month Day 2012 0ct Medical 3:00 A M 6 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise of Columbia Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) **Director** 213-20-7007 1 X M 2 □ F Dec.28, 1923 Ohio Usual Residence of Decedent ?7 is marked other then "natural", or items 23a or 28a-f show traumetic event, the Vecical Exeminar must be notified at 10a. State filed within 72 hours efter death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Baltimore Parkville 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9079 Waltham Woods Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 I Hyglene, other then "natural", 1 ☐ Yes 2 🎾 No Specify: 3 N Widowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Vice President Printing Company Be permit. Pege 1 and 2 should be filed Department of Health and Mentel Hy important: If item 27 is marked oth any injury or other traumetic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
UNK Harry F. Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy E. Westrom - Daughter 5255 Candy Root Court, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 10/11/2012 Elkridge, Maryland 21. Sign yur of uneral Service License 22. Name and Address of Facility Gary L. Kaulman F.H. UMMP MO1283 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Exter the dise se, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuri. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant : 9 Unknown Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) ၉ 1 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Spec Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number Cify or Town, State

the Hospital or Attending Physicien: The lew requires thet the death certificate be executed thin 24 hours effer death.

the Funeral Director: After this certificate has been signed by the ettending physicien and mpletely filled in by the funeral director, page 2 should be deteched for use as the burlel-trensit Division of Vital Records, P.O. Box 68760 Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Funei completely fi 29a. Certifier 3 Confifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi V~ D d address of person who completed cause of death (Item 23a) (Type, Print) 621.5 State 32. Registrar's 7 Registrar DHMH 17 Rev 06-2011 **ORIGINAL**

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			For State Registrar	Otato of Ma	, yidi i		Certificate of L		nontal m	Reg. No.	201	2 3339
П	Physicia	n/	Decedent's Name (First, Middle, Last)	1	1.1	17	revs		2. Date of Do Month	Day		3. Time of Death
-	Medic Examin		4a. Facility Name (if no institution, give str	reet and number)	<u>~</u>	a 1		r Location of Death	1		County of Deat	1350 PM
	•		Mandrin Hospice Ho				Harwood				nne Aru	
п	Funeral Director		5. Social Security Number 6. Sex 1	7. Age	(In yrs. la:	st birthda Yrs	Months Days	Hours Min.	8. Date of Bi (Month, D	ay, Year)		thplace (State or Foreign untry)
	Mod #	_	Usual Residence of Decedent 10a, State 10b, County				Location		4/18/1	1922		N.C. 10d. Inside City Limits
	Aarylan Ba-fst	ecto	MD Anne Aru			ever						1 ☐ Yes 2XXNo
	h the h	Funeral Director	10e. Street and Number				10f. Zip Code			-	zen of What Co	ountry?
	ath wil	uner	1462 Washington Av	e 2. Was Decedent Ev	er in U.S.	. 11	3. Was Decedent of H		ecify Yes or No		SA 4. Race - Ame	rican Indian
98	fter de ", or its amine	þ	1 Never Married 2 Married	Armed Forces? ▼▼ Yes 2 □ N If Yes, Give			If Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, White	
Ö	nours a	Completed	3XXWidowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates.		16a. De	cedent's Usual Occur				nd of Business/	
215	nin 72 l ne. chan "r	ошо	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+	,	life	ive kind of work done b. DO NOT use retired) 11-	during most of work	ing	1.	ivil Se	-
d 21	led wit Hygier other i	BeC	12 17. Father's Name (First, Middle, Last)				lerk	18. Mother's Nam	e (First, Middle			TVICE
ylan	id be fi Mental arked artic ev	၉	Joseph Pack					- Unkno	Wn-	rgare	t M. Pa	ick
Mar	2 shou th and 27 is m traum		19a. Informant's Name/Relationship (Type Mr. Daniel Walters			1	ailing Address (Street 62 Washing				Town, State, Zip 21144	Code)
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy follury or other traumatic event, I'm M. clic. I Examiner must be notified at once.		20a. Method of Disposition		20b. Pla	ace of Di	sposition (Name of crematory or other place		Date		cation - City or	Town, State
timo	t. Page tment tant: It		1 ∏Burial 2 ☐ gremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)				rans Cemet	ery 10/2	2/2012	Cro	wnsvill	e, MD
Ba	permit. Departn Importa any inju	, J	21. Signature of the Service Licensee		0122		22. Name and Addre					remation, MD 21061
			23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one									Approximate Interval Between
	nysician/ Medical	8 1	Immediate Cause (Final disease or condition resulting in death)	າ			OPD					Onset and Death
-	Examiner			Due to (or as a	conseque	ence of):						
	it d	Examiner	Sequentially list conditions, b. if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):						
D.	executed an and rial-transi	Exar	that initiated events c. resulting in death) Last	Due to (or as a	conseque	ence of):						
		dical	d.									
687	certifica Iding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If <u>ye</u> s, outcome of		ісу				2	3d. Date of del	ivery
Box 68760	death o	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 W No	1 Live Birth 2 4 Pregnant at t 9 Unknown		death eath	3	су			Month	Day Year
Ö.	hat the ed by ti detach	y Phy	g	ributing to death but	not resu	Ilting in th	ne underlying cause ai	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ds, F	quires t	d pa	Viseus p.	n For a	Ac	ph	7,4		75	Yes 2	No 3□Pr	robabiy 4 🗆 Unknown
Division of Vital Records, P.O.	3 2 3	Completed by	intras de	mina	Q	9	Scen		24a. Was	DSV		topsy findings available completion of cause of
<u> </u>	rsician: The faw r s certificate has b director, page 2 s	Be Co	25. Was case referred to medical				26. P	lace of Death (Checi		ormed? 2 No		2 🗆 No
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n o	nding F ith. : After t e funer	cate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,		28b. Time injur	y worl		28d. Describe	how injury	occurred H	iospia Hou
visio	or Atter frer des irector n by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		ne, farm,	street, factory, office		28f. Location (Number or Rur	ral Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 burs after death. within 24 burs after death certificate has been signed by the attending physici To the Euhneral Director. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the burst of the completely filled in by the funeral director.		29a. Certifier 1 Certifying Physici	ian: To the best of m	y knowle	edge, dea	th occurred at the tim	e, date and place, a	nd due to the o	ause(s) and	d manner as sta	ated.
	the Ho hin 24 I the Fu npletely	Medical	(Check 2 Medical Examine only one) 3 Certifying Nurse I	r: On the basis of exa	mination	and/or in	vestigation, in my opinion	on, death occurred a the time, date and pla	the time, date	and place, a	and due to the o	cause(s) and manner stated.
	Cor wit		29b. Signature and title of certifier			м	29c. Licens	e number	1	29d. Date	signed (Month	, Day, Yelar)
	/X		30. Name and address of person who com	npleted cause of dea	th (Item	23a) (Typ	e, Print)	11			(0)	7/10
	Stat	0	EVA HERCH 31. Date filed (Month, Day, Year)	32. Registrar	S Signatu	ure 🕖	etense	High	ay A	nnaz	MD	2140)
	Registra		OCT 1 7 2012 Sen	un B.	40	Ma						

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		1- For State Registrar Certificate of Death	and Mental Hyg		201	2 3341
Physic ledical Exam		1. Decedent's Name (First, Middle,Last)		Date of Deat Month	Day Year	3. Time of Death
		4a. Facility Name (if not institution, give street and number) 4b. City, Town	n, or Location of Death	October 1	1, 2012 4c. County of Deal	1904 hrs
Funeral		St. Agnes Hospital Baltimor 5. Social Security Number 6. Sex 7. Age (In yrs. last hirthday) 15 ladge 1			NA	
Director		a dide i	2 11 11		7-1958 Forei	irthplace (State or ign ountry)
v any		10a. State 10b. County 10c. City. Town or Location				10d. Inside City Limits
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death with the Maryland or items 23a or 28a-f sho must be motified at once	Il Director		1215	10	g. Citizen of What Cou	ntry?
eath wi	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Armed Forces? If Yes, specify Cu	Hispanic Origin? (Specif ban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
rs after d ural", or miner m	Š	3 Widowed 4 Divorced If Yes, Give Year or Dates:	No specify:			lack
6 72 hou	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occuduring most of working	life. DO NOT use retired)	done	16b. Kind of Business/ Bouth a	
-003 within giene. her th	omp	17. Father's Name (First, Middle, Last)	Keeper		County.	Schools
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after and of Effect within 72 hours after not of Health and Mental Hygene. Intel If I feen 27 is marked other than "natural", or other traumatic event, the Medical Examiner I other traumatic event, the Medical Examiner	Be	beorge Muldrow	18. Mother's Name (Fir	a	Hara	
MD 2 hd 2 should hith and M m 27 is m numatic c	7	19a. Informant's Name (Relationship (Type, Print) 19b. Mailing Address (St 19c Wallau husband 4 £23 W	reet and Number or Rural	Route Numb	er, City or Town, State	, Zip Code)
re, respirate transfer transfe		20a. Method of Disposition 20b. Place of Disposition (Name of Cremation 3 Removal from State crematory or other place)	cemetery, Da		20c. Location - City or	
- 5391		4 Donation 5 Other Specify: Mt Zcon		0-/2	Lansda	one, mo
Balt permit. Departi		21. Synature of Funeral Service Licensee 22. Name and Addre	7900	5 W.	Frankle	n-St.
Physician /Medical		23a. Part. Exter the disease, or complications that caused the death. Do not enter the mode of dyr failure. It is only one cause on each line.	m. Wada	piratory arrest	shock, or heart	Approximate Interval
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascu Due to (or as a consequence of):	lar Disease			Between Onset and Death
		Sequentially list conditions, b				
	mine	if any, leading to immediate Due to (or as a consequence of): couse Enter Underpring Couse (Disease or injury that initiated				
Tansit and A	EX	events resulting in death) Last Due to (or as a consequence of): d.				
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38760, rtificate be ing physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery	
Box 687 e death certific the attending p ed for use as th	hysician/	1 Yes 2 No 9 V Unknown 9 Unknown 9 Unknown			Month Da	ay Year
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ls, P. C	8				No 3 Proba	
Cords, law require has been s	omplete			24a. Was an autopsy	prior to co	ppsy findings available mpletion of cause of
tal Rection: The certificate ector, page	ა ∟	25. Was case referred to medical			d? death? No 1 ✓ Yes	2 No
hysician ruhis ce	0	1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	e of Death (Check only or Other Nursing Hom		sidence 6 Other:	
		Natural 5 Pending (Month, Day, Year)	⊔ry at Work? 28d. [Yes 2 No	Describe how	injury occurred	
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Ospital hours uneral		4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the heat of pulsars and the second secon		r Iown, State))	
To the Ho within 24 h To the Fur completely	5 1	Certifying Physician: To the best of my knowledge, death occurred at the time, done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	ate and place, and due to n, death occurred at the ti	the cause(s) me, date and	and manner as stated place, and due to the o	cause(s)
	2	29b Signature and title of certifier 29c. Licens			d. Date signed (Month	
H	3	O.C. Name and address of person who completed cause of death (Item 23a)	M.E. ————————	0	ctober 12, 2012	
Y		Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltir	nore Street, Baltime	ore, MD 2	1223	
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature 3. Advisory States				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death - 1<u>8</u> Physician/ Charles Thomas Aberts, Jr. <u>September</u> 2012 9:00 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Hou*r*s Director 213-38-9571 1 📈 M 2 🗆 F 71 Feb 7, 1941 Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 2922 Roop Road 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Glass Company Estimator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Charles T. Aberts, Sr. Thelma Kram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Aberts, wife 2922 Roop Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State All Faiths Crematory 9/24/2012 Manchester, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore Št, Taneytown, MD 21787 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CORONARY ues Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): The law requires that the death certificate be executed Cause (Disease or injury physicien and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph d for use as th 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 No 1 Yes 2 No Yes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No Other: ၉ 1 Yes 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inp 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ne Hospital or Attendiny in 24 hours after death.

The Funeral Director: Aft pletely filled in by the fur Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check To the I within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31660 19/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STONER AVENUE WESTMINSTER MANUFACALIST THOMAS IN GALVIN'IL MS 295 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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St	te of Maryland / Department of Health and Mental Hygiene	

	State of Maryland 1- For State Registrar	Certificate o		, ,	Reg. No. 201	2 334
Physician. lical Examine	Decedent's Name (First, Middle,Last)	RCHIBALD		2. Date of Dea		3. Time of Death
·	4a. Facility Name (if not institution, give street and number		4b. City, Town, or Location		er 28, 2012 4c. County of Death	
	In Bay near Duck Ln		Bishopville		Worcester	
Funeral Director		ge (In yrs. last birthday) Yrs	Months Days Ho	urs Min.	7. Tth (MM/DD/YYYY) 9. Bir Foreig Co	thplace (State or In NEW JERSE) untry)
w any	10a. State 10b. County	10c. City, Town or Locat				10d. Inside City Limits
Aaryland 28a-f show l at once.	DELAWARE SUSSEX COUNTY 10e. Street and Number	SELBYVILI	10f. Zip Code		l0g. Citizen of What Cour	1 Yes 2 X No
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er death with t , or items 23s r must be not Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces 1 Yes 2	at Ever in U.S. 13. Wa i? If Y	as Decedent of Hispanic C res, specify Cuban, Mexic	Origin? (Specify Yes or No can, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
ral", o	or Dates:	1	Yes 2 X No speci	•	Specify: WHI	
2 hour "natu	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or	durino m	nt's Usual Decupation (Given state of working life, DO NO	ve kind of work done OT use retired)	16b. Kind of Business/I	ndustry
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ATZT: ATZT: Ould be fil d Mental I s marked fic event, I		19b. Mailing	g Address (Street and N	_	RRIS nber, City or Town, State,	Zip Code)
nd 2 sho alth and in 27 is	SUSAN M. ARCHIBALD (MOTHER	-	BIXLER RD.		·	
permit. Pages 1 and 2 shou Department of Health and N Important: If item 27 is n injury or other traumatic	20a. Method of Disposition 1 Burial 2 Toremation 3 Removal from St	tate crematory or oth		Date	20c. Location - City or	Town, State
Dalumore, permit. Pages l ar Department of Hes important: If ite njury or other tr	4 Donation 5 Other Specify: 21. Storatur of un al Service Licensee		CREM. CTR.			
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box oor of death certificate the attending phy ed for use as the hysician/M	23b. Was decedent pregnant in the past 12 months?	2 Fet	tal death 3 Ector	oic pregnancy	Month Da	ay Year
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= 2 = - I C)		. I a suit a deservation of a server				
vithin 24 hc. Forthe Fund ompletely f.			on, in my opinion, death o	couried at the time, date a	and place, and due to the	cause(s)
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29c.License number		29d. Date signed (Mont	h, Day, Year)
2	29a. Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated. 29b. Signature and title of certifier	mination and/or investigati				h, Day, Year)
2	Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigati	29c.License number		29d. Date signed (Mont September 29, 20	h, Day, Year)
To the Hosp within 24 hosp within 24	29b. Signature and title of certifier 30. Name and address of person who completed cause of de Mary G. Ripple MD. Deputy Chief Medica 31. Date filed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of de Mary G. Ripple MD. Deputy Chief Medica 31. Date filed (Month, Day, Year)	mination and/or investigati leath (Item 23a) cal Examiner 900	29c.License number O.C.M.E.		29d. Date signed (Mont September 29, 20	h, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September Day 19, Ida Dorothy Barnard 2012 8:00 a M Medical 4a. Facility Name (if not institution, give street and nur Healthcare Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Lutheran Village Center Westminster Carroll 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea. Funeral 214-26-9977 83 Director 1 M 2 X F Maryland Jun 20, 1929 28a-f show ms 23a or 28a-f shormust be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll Maryland Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 St. Mark Way 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, If item 27 is marked other than "natural", or iten or other traumatic event, the Medical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify Specify: 3 Widowed 4 Divorced white Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Secondary (0-12) Health Dept. Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 2 John Joseph Dawson Ida Dorothy Abbey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Hall, daughter 1 and 2 s of Health item 27 139 Bourbon Court, Perry Hall, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Cokestur vat Methodist 9/22/2012 ☐ Donation 5 ☐ Other (Specify) Abingdon, MD Church Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician a Physician/Medical that the death certificate be IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? 1 Yes 2 No 9 Unknown Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

within 24 hours a

Registrar

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner city, Town, or Location of Death 4c. County of Death illiams Stone 6. Sex . Age (In yrs. last birthday) **Funeral** Year If Under 24 Hrs 8. Date of Birth State or Foreign Dec 20, 1938 Countr **Director** 212-38-6598 1 **X** M 2 □ F 73 Usual Residence of Decedent 28a-f shov 10a. State notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Allegany Flintstone 1X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 18209 Williams Rd. SE 21530 USA or items 12. Was Decedent Ever in U.S. Examiner Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", If Yes, Give Completed 3 X Widowed 4 Divorced white Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) the <u>mechanic</u> Stroehman's bakerv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard S. Bennett Grethel Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Bennett 18209 Williams Rd SE wife Flintstone MD 21530 Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ry, crematory or other place) 1x Burial 2 Cre ion 3 - Removal from State Glendale Cemetery 10/12/2012 Donation 5 Othe (Specify) Flintstone MD Signature of Funeral Service 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner AD Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed TN and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy perform Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No 1 Yes Other: |은 1 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) 29a. Certifier Certify no Physician: To the best of my/knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practifiener: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (It

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			Registrar				Cer	tificate of	Death			Reg. N		12	334	UJ
	Physici Medi		1. Decedent's Name John		st) Fielding		В	armon			2. Date of Dea Month Octobel	Da	ay 2012	ear	3. Time of Deat 4:15 P	:h M
-	Exami		4a. Facility Name (if n		e street and number) Day Road,	NT TaT		4b. City, Town, o		of Death	roccoper		c. County of	Death		
	Funeral		5. Social Security Nur				ast birthday)	If Under 1 Year	aVale	24 Hrs.	8. Date of Birth				gany	
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900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		12. Was Decedent I Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates.		If	/as Decedent of H Yes, specify Cuba Yes 2 X No		jin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		14. Race - Black, \ Specify:	White, et		
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Baltimore, Maryland 21215-0036	Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Dispos 1 ☐ Burial 2 🛣 4 ☐ Donation 5	Cremation 3	Removal from State	C	lace of Dispos emetery, crem nberlar	ition (Name of atory or other place ad Cremat	ory 1	_	I		ocation - Cit			
Balt	permit. Departi Import any inj		21. Simetur, of Fune	ral Service Ocens	an6			Name and Addre							me, P.A 502	•
			23a. Part 1. Enter the shock, or heart f	e disease, or com failure. List only o	plications that caused ne cause on each line	the death	. Do not enter	the mode of dyin	g, such as c	ardiac or	respiratory arre	st,			approximate	
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		State of Maryland / Department of Health and	Mental Hy	giene	
		Registrar 1. Decedent's Name (First, Middle, Last) Certificate of Death		Reg. No. 2 U	12 33406
Physicia			2. Date of De Month		3. Time of Death
Medic Examir		Charles Claude Brooks Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	9_		
_//		Mallard Bay Care Center Cambridge	alli	4c. County of Dorches	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs	O. Date of Dir	th 9.	Birthplace (State or Foreign
Director		220-16-9348 1 ☑ M 2 □ F Yrs. Months Days Hours Min	(,	-1928	Country) MD
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nd 21215-0036 (C.C.) filed within 72 hours after death with the Maryland all Hygiene. d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	Funeral Director	418 Phillips Avenue 21613		USA	
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Maryland 21215-0036 (()	-		ia Caste		
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Page 1 nent of ant: If it ury or o		1 😾 Burial 2 🗌 Cremation 3 🗌 Removal from State 🔀 cemetery, crematory or other place)		Cambridg	·
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Geath death he attended for a	sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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1,		. / /	73	10/1/12	on, Day, rear/
4		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)		10. 110	
		Patrick Johnson, Do 100 Bramble Cambr	idse,	MD	
State	3	31. Date filed (Month, Day, Year) OCT 9 2 2012 (32. Registrar's Signature			
Registra		OUT ON LUIL PORTE P. MOUNT			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0530 M Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) December 2, 1928 **Funeral** 7. Age (In yrs. last birthday) 213-40-8433 Birthplace (State or Foreign Country) **Director** 1 □ M 2 🕱 F 83 Vírginia 28a-f show with the Maryland 10a State 10c. City, Town or Location Director 10d. Inside City Limits notified MD Prince Georges Bowie 1X Yes 2 No ō 10e Street and Number 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important if item 27 is marked other there any injury or other traumate. Funeral 6207 Gallery Street 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Narried Black, White, etc 1 ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Buyer Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles W. Green Rose Cloud 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William F. Bird Jr./ Husband 6207 Gallery Street Bowie, MD 20720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arifigton National Cemetery 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/24/2012 Arlington, VA Donation 5 Other (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ nsat and Death disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the Attending resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the nding pl JE FEMALE nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death Pregnant at time of death ō in the past 12 months? signed by the at d be detached fo Month Day 2 12 No Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: P 1 Nnpatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗷 Natural 2 Accident
3 Suis 5 Pending Investigation 1 Yes 2 No 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Definition in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 60 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Mo.

SEP 28 201

Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

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		Social Security No. 577–62–0 Jsual Residence of	872	Sex 1. X OXM 2F	7. Age (In yrs. I 84	ast birthday Yrs.	Months	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 08/07/	ay, Year,	8	Count	lace (State or Fore ry) Cuba
Director	10	a. State	10b. County	George'		y, Town or	Location Shingt	on		<u> </u>	···			10	0d. Inside City Lim 1 ☐ Yes 2 1
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09/27 2012 Year James Elmer Chance Medical 12:25p M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hartley Hall Nursing Home Pocomoke City Worcester Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country)
 T77 223-26-0372 1**X** M 2 □ F Days Hours Director 0770971917 VA Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f sl notified Accomack Saxis 1X Yes 2 No 10e. Street and Number ems 23a or r must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral 20214 Saxis Rd. 23427 USA items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 14. Race - American Indian, Armed Force ō þ 1 Never Married 2 Married Black, White, etc. 1 Yes : 2 X No Baltimore, Maryland 21215-0036 "natural" 1 ☐ Yes 2X No Specify. Completed 3 X Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o 2 Colie Chance permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic or Vivian Bonawell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Bailey/Daughter 111 Fountain Dr., York, PA, 17402 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place John W, Taylor Cem. 09/30/12 4 ☐ Donation 5 ☐ Other (Specify) Temperanceville, VA 21. Si par re of Ineral Service Licensee 22. Name and Address of Facility Thornton Funeral Home 24183 Chadbourne St., Parksley, VA, 23421 23a. Part 1. Enter the disease, or complic ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 1 NEUMONIA Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** (LENA FAILURE Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or linjury Due to (5r de a consequence of, and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the a Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No page certificate 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: ျ this 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and tile of certifie 29d. Date signed (Month, Day, Year)

Registrar

Shame and address of person who completed cause of death (Item 23a) (Type, Print) Shame) L Say AL, MI) 1604

SAMAL, MI)

egistrar's Signatur

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MARLKET ST.

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POLOMOKE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and	Mental Hygi	ene	
	_			rtificate of Death	Re	g. No. 20 2	2 33410
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 9 / 24		3. Time of Death
	Medic Examin		Leland J. Compton, Sr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	3:08 A ^M
_	/	•	Carroll Hospital Center	Westminster		Carrol	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.			nplace (State or Foreign
	Director		216-30-0987 79 Yrs. Usual Residence of Decedent		2/17/19	933	WV
	land shov dat	tor	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Mary 28a-1 notifie	Director	MD Frederick Mt. A				1 Yes 2XXNo
	ith the 23a or st be r		10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
	ems a	Funeral	4400 Buffalo Rd. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21771 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	USA 14. Race - Ameri	can Indian
ထ္ထ	fter de , or it	by	1 L Never Married 2 LX Married 1 LX-Yes 2 L No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	o Rićan, etc.)	Black, White,	
Ö	ours a	Completed	3 Widowed 4 Divorced If Yes, Give Year or Dates. 1951–59	1 Yes 2 X No Specify:		Specify: Wh	ite
7	72 hc	mple	(Specify only highest grade completed) (Give	edent's Usual Occupation I kind of work done during most of wo DO NOT use retired)	rking 1	6b. Kind of Business In	ndustry
Maryland 21215-0036	within 72 hours after death with the Maryland giene. Ier than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		College (1-4 or 5+)	rict Sales Manage	er	Cleaning S	Services
D L	tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Ma	iden Surname)	•
3	should be file and Mental I 7 is marked or raumatic eve	_	Loring Jackson Compton 19a. Informant's Name/Relationship (Type, Print) 19h. Maii		J. Ruckm		
¤ ∑	0 ± 2 ±	25	Tob. Man	ing Address (Street and Number or Ru) Buffalo Rd., Mt.		-	Code)
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra once.		20a. Method of Disposition 20b. Place of Disp			Oc. Location - City or T	own, State
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3alt	permit. Depart Import any inj	ij		2 Name and Address of Facility Burrier-Queen Fur		& Cremato	ry, P.A.
	HH = 6 0		23a. Part 1/Enter the disease, or complications that caused the death. Do not en	1212 W. Old Liber			
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	Medical		Immrediate Cause (Final discrete or condition resulting in death) a. Due to (or as a consequence of):	ing o pooring			Onset and Death
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6876	certificat nding ph use as th	/Mec	IF FEMALE:			1	
Box	death ce the attend ted for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 Use Birth 2 Fetal death 3 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deliv	rery Day Year
	he de	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 g Unknown				
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Division of	al or A s after 1 Direc d in by		4 Homicide determined 28e. Place of Injury - At nome, farm, st building, etc. (Specify)	eet, ractory, office	City or Town, S	et and Number or Rura State)	Houte Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inversions)	occured at the time, date and place, a	nd due to the cause	(s) and manner as state	ed.
	the H thin 24 the F mplet	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and pla	ice, and due to the ca	use(s) and manner as st	ated.
	7 ≥ 7 0 0		Lacto MD	D C20 31	290	d. Date signed (Month,	14 2012
			30. Name and address of person who completed cause of death (Item 23a) (Type,	D52035 ex A Wen		7	(
0	KJ6+1VA	}	BINU CHACKO 295 Stor	er /N Wen	muta	MO 2	110
	Stat Registra	e ır	31. Date filed (Month, Day, Year) SFP 2 7 2012 32. Registrar's Signature	basse			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month September 28 ^{Year} 201 Marcellus I. Davis Sr 7:45AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 10 Hicks Ave Apt 2E Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days Hours (Month, Bay, 1935 217-32-9111 Maryland Director 1**X** M 2 □ F Dec 76 Usual Residence of Decedent item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Annapolis 1 Yes 2 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21401 USA 10 Hicks Ave Apt 2E Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Black Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry should be filed within 72 hand Mental Hygiene. 7 Is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9th Laborer Anne Arundel Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hester Green Paul Davis t. Page 1 and 2 should by treet of Health and Mertant. If item 27 Is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcellus I. Davis Jr(Son) 8209 Averill Ct. Severn, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of I
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 CCremation 3 Removal from State 10-1-12 Metro Crematory Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Miname a Received RecilitSons Mortuary, P.A. 21401 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ TRACHEAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician end d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 s autonsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 Z No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗆 Yes 2 🗀 No 1 Natural injury 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifie 29c. License number CM. D5665 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21401

CX4

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

OCT 01

Scuta 400 116
gistrar's Signature

ANNAPOLIS MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6 2012 10:25 4c. County of Death Carroll Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1934 Maryland 10d. Inside City Limits 1 🗆 Yes 2 🛣 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. white Specify: 16b. Kind of Business/Industry doctor's office 20c. Location - City or Town, State Hampstead, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

5

4231 Northwoods Trail

Jocha

Dominas

Hampstead, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Theodore Doukas, Jr. September 7:56 A 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll County 4764 Millers Station Road Hampstead Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 578-56-4312 1 X M 2 D F Director 69 Feb. 8, 1943 Virginia Usual Residence of Decedent shov 10a, State 10b Count 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director must be notified Carroll County Maryland Hampstead 28a-f 1 Yes 2X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4764 Millers Station Road 21074 United States death ıral", or item Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 Pes, Give Saltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after dåtes 1 ☐ Yes 2 X No Specify. white "natural" Completed 3 Widowed 4 X Divorced Specify: Year or Dates. unknown the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) mechanic motorcycle repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret (maiden name unknown) James Theodore Doukas, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan K. Cherbousky / partner 4764 Millers Station Road Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept^{Date} 21, Page 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6 Department of Important: If any injury or once. Carroll Cremation Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Line 22. Name and Address of Facility Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ ena 1011 lure disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 L 9 Unknown the 8 be detached Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the state of the sta signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifier MD0670336 20/12

2036

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Howard H. Farrington

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		_	For State Registrar	Otate of Mary		tificate of E			2012	33414
	Physicia	n/	1. Decedent's Name (First, Middle, Last Jessie Elizabe	,				2. Date of Death Month	Day Year	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give			4b City Town or	Location of Death	Sept. 20	4c. County of Deatl	1:45 p м
****	LAdillii	CI	Gilchrist Cente		.ce Care	Towson	Location of Beatin		_	timore
	Funeral Director		5. Social Security Number 6. Se 215–24–5322	x 7. Age (In ☐ M 2 🛣 F 84	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) Cou	hplace (State or Foreign Intry)
	D WO #	_	Usual Residence of Decedent 10a, State 10b, County		c. City, Town or Lo	nation		oct. 6,	1927 MD	40.11.11.07.11.17
	/anyłan 8a-f sh tified a	Director	MD 166. Godiny	10	Towson	Sation				10d. Inside City Limits 1 ✓ Yes 2 No
	th the N 3a or 2 t be no	a	10e. Street and Number 6451 N. Charles	Stroot		10f. Zip Code 21212)	10	g. Citizen of What Co	untry?
	ems 2	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V		spanic Origin? (Spe	cifv Yes or No-	14. Race - Amer	ican Indian
900	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ODGs.	<u>اچ</u>	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates.	1	f Yes, specify Cuba □ Yes 2 X No	n, Mexican, Puerto	Rican, etc.)	Black, White Specify: White	e etc.
15-(72 hou	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	I (Give I	lent's Usual Occup kind of work done o O NOT use retired)	ation luring most of worki	ng 16	6b. Kind of Business/	Industry
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Baltimore, Maryland 21215-0036	ild be filed Mental Hy iarked ott atic even	To Be	17. Father's Name (First, Middle, Last) Guy Kenneth Gil	.1			18. Mother's Name Elizabe	e (First, Middle, Mai eth Sutto	iden Surname) N	
, Mar	nd 2 shou ealth and n 27 is m		19a. Informant's Name/Relationship (Type William C. Enso				and Number or Rura bad, Phoer		ity or Town, State, Zip 1131	Code)
Jore	ge 1 ar nt of He :: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State		natory or other place	e)		Oc. Location - City or	
altin	mit. Pa bartme bortant injury	1 (9	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License		Carroll C	Name and Address			mpstead, Meral Home	שוי
<u>~</u>	Dermi Depar Impor any ir		1 Thanks L	Lamme	و ر	. Hampste	stead, MD 21074			
	Physician/ Medical Examiner	er	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. Due t (or as a co	UMM insequence of): MCM	r the mode of dyin	g, such as cardiac d	r respiratory arrest	,	Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	dical Examiner	if any, leading to immediate eauee. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co					2	
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. On the Funeral <u>Director</u> : The this certificate has been signed by the attending phy: completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past to months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	JFetal death 3 L	Ectopic pregnanc Other (specify)	:y		23d. Date of del Month	ivery Day Year
ds, P.C	quires that t an signed b ruld be deta	ک	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	indertying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Recor	≥ 8 0	Completed			14			24a. Was an autopsy performe	prior to death?	copsy findings available completion of cause of
ta	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Check	only one)		
ž	ding Physi h. After this c funeral dir	일:	27. Manner of Death		2 ER/Outpatier		4 ∐ Nursing Ho	me 5 Residence 28d. Describe how	ce 6 Other (Speci	in Mospie
ouo	ending eath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ear) injury	work	? Yes 2□No	Edd. Describe now	ngary occurred	
Divisi	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S		eet, factory, office	-	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	he Hospi in 24 hou he Funer pletely fill	Medical	(Check 2 L Medical Examin	ician: To the best of my ner: On the basis of exam e Practitioner: To the be	ination and/or inves	tigation, in my opinio	on, death occurred at	the time, date and	place, and due to the o	ause(s) and manner stated.
	o de la la la la la la la la la la la la la		29b. Signature and the of certifier	lus		29c. Licenso	58303	5	d. Date signed (Month	Day, Year) 2012
	12		30. Name and address of person who c			Charce	o ST TO	men 1	M) 212	04
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	hall				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09/24/2012 Physician/ Bienvenido Abella Enriquez 11:49 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Director 210-76-2887 XXM 2 D F 77 03/03/1935 Philippines 28a-f show 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes XX No Maryland Prince George's Ft. Washington 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2012 Belfast Drive 20744 or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 Yes 2 No Specify: Filipino Pilipino Completed 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Tokai Shipping Co. Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marcelo Cerujano Enriquez Fausta Abella Salazar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or extension Loreto Catalma Enriquez / Wife 2012 Belfast Drive Ft. Washington, MD 20744 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 9/29/2012 Kalas Crematory 4 Donation 5 Other (Specify) Edgewater, Maryland 21. Signature of Ednaral Solvice License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Physician/ disease or condition unknown Medical resulting in death) Due to (or as a consequence of): Examiner HYPOTENSION unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) unknown the burial-transit THYMUS CARCINOMA Due to (or as a consequence of): resulting in death) Last physician Physician/Medical CHRONIC OBSTRUCTIVE LUNG DISEASE unknown Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter d be detached for Dav Pregnant at time of death g Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 1 No Hospital Other: ပ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending iniury 1 Yes 2 No Accident 2 Accident Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier ertitying Phys and To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Practitionary To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Exami only or ertifying Nu 29b. Signatu 29c. License number mpleted cause of death (Item 23a) (Type, Print) Arastoo Yazdani 9135 Piscataway Rd. Clinton, MD MD20735 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9 Physician/ 1155AM lance Hear Eugene 2013 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death of Maryland Inversity Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Hours Country) **Director** 229-62-7821 1 XM 2 - F 65 Yrs Apr. 7, 1947 Virginia Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland must be notified at Director Maryland Carroll County Hampstead 1 Yes 2X No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 4310 Royal Avenue 21074 United States ral", or items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give Black White etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white "natural", 3 Widowed 4 Divorced Year or Dates th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) construction worker construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Vance Hearn Frances Archer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine L. Hearn / wife 4310 Royal Avenue Hampstead, Maryland 21074 20a. Method of Disposition
1 □ Burial 2 X Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept Date 26, Carroll Cremation Hampstead, Maryland 4 Donation 5 Other (Specify) 2012 . Signatur**g of** Funeral Service Lice**r**Se 22. Name and Address of Facility Eline Funeral Home M01072 Han 934 South Main Street Hampstead, Maryland 21074 www 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on ea Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner rastro in testin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner oua to for as a consequence on To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury 21 the burial-tran that initiated events resulting in death) Last Physician/Medical Schen Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ ☐ g ☐ Unknown Yes Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed 2 No Yes 2 1 🗌 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 \sum Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) . Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending М 2 🗌 No 2 Accident Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 🗹 🎖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certified 29c, License number

State Registrar Sunjeer

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sidho

22 N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 26 Physician/ Tawes Patrick Harper 2012 6:00 p M Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dorchester Mallard Bay Care Center Cambridge Social Security Number 1 Year Jf Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Davs 216-14-9127 88 Director 1 X M 2 🗆 F Yrs Feb. 9, 1924 Maryland 10d. Inside City Limits "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10c. City. Town or Location 10a State Director MD Dorchester Cambridge 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country?
USA 10e, Street and Number 21613 434 Leonards Lane Funeral be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)

owner/operator (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) engine repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental marked c ည Georgia Dixon George Harper 1 and 2 should b if Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 434 Leonards Lane Cambridge, MD Olive M. Harper wife other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once, Page 1; 1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cem 10/2/12 Hurlock, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Thomas Funeral Home P.A. Cambridge, MD 21613 700 Locust St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ tastatic Drostate IEDVS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to or as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No this certificate has been signed by the atternal director, page 2 should be detached for Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes the funeral director. Be 25. Was case referred to medical Hospital 2 14 No Other မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours arter comes Funeral Director: After 1 Natural work?
1 Yes injury 5 Pending 2 🗌 No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar nnsor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Elsie Catherine Knight Sept 2012 Medical 4 23a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dove House Hospice Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) 7/10/1920 Months 215-18-7252 Director 92 1 M 2 XF MD Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Martel Hygene. 27 is marked other then "natural", or items 23s or 28s-f show traumatic event, the Medical Exerthan mat be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Adams Littlestown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 720 Sell Station Road 17340 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Divorced Specify: white Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) homemaker 11 own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ William Christian Schmitt Martha Klotzbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Haalth e Donald K. Knight, husband 720 Sell Station Rd., Littlestown. PA 17340 3altimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) parmit, Paga 1 e
Dapartmant of H
Important: if ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Memorial 9/27/2012 Finksburg, MD 21. Signature of Funeral Service Licensee M00741 22. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burlal-transit that the death cartificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signad by tha attanding physician Id ba datachad for usa as tha burlai Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 5 Other (specify) Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown paga 2 should baan 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cartificata has autopsy 1 ☐ Yes 2 ☑ No Yes 2 No To the Hospital or Attanding Physician: I within 24 hours aftar death.
To the Funeral Director: Aftar this cartifice complataly fillad in by the funeral director, to 25. Was case referred to predical **Division of Vital** å 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ဍ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nursip Practitioner: To the best of my knowledge, death occurred at the time, date and blace and due to the cause(s) and momer as stated only one nd title of certifier 29b. Signature Hleua rem 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Breezes 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Elizabeth Marie Loudenslager September 2012 9:47 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last hirthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 213-38-5936 89 Feb 17, 1923 Virginia Usual Residence of Dece r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 201 St. Mark Way, Apt 413 21158 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumasis Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Rutherford Susie Costello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Loudenslager, daughter 107 Setting Sun Ct, Stephenson, VA 22656 20b. Place of Disposition (Name of cemetery, crematory or other place) PK 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Lake View Memorial 9/29/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis St, Westminster, MD 21157 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Part . Enter the disease, or complications the shock, or heart failure. List only one cause on Approximate Interval Between MALIGNANC Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deeq be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) Pregnant at time of death Month Year a Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 - No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec DPANE 2- No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ar 29d Date signed (Month, Day, Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. R State 2 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical PAT 4a. Facility Name (if not institution, give teet and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medical ton **Funeral** Year If Unde Birthplace (State or Foreign Country) 8. Date of Birth 283-46-9432 (Month, Day, Year) Months **Director** 1 🗆 M 2 💢 F 62 Yrs 7/30/1950 Ohio "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Davidsonville 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 745 Governor Bridge Rd. 21035 USA death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 Yes Give 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Bookkeeper Assisted Living 1 and 2 should be filed w if Health and Mental Hygi item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Howard Long Estella Moore or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chanon Campbell/ Daughter 404 Pinnacle Drive Bunker Hill, WV 25413 item 20a. Method of Disposition permit. Page 1 a
Department of F
Important: If ite
any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Kalas Crematory 09/27/2012 Edgewater, Maryland 21. Signatur Funeral S 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition SMAI Medical resulting in death) Due to (or as a conse Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) sician and burial-transit Exami resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for 5 Other (specify) Pregnant at time of death Day detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Ves 2 No Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this filled in by the funeral Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) work 1 Yes Accident Investigation 2 🗆 No after death 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Hospital 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check within 2 To the F only one) Ecrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Name and address of 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 06-2011

State of Maryland / Department of Health and Mental Hygiene 20 | 2 33423 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month STINEY ALBERT 10:35 PM **MASAITIS** September 26 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick <u>Frederick</u> **Funeral** . Social Security Number 181 -- 03 -- 48287. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 95 Director 1 🕅 M 2 🗆 F Pennsylvania March 10,1917 ral", or iteme 23a or 28a-f ehor Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7907 Dance Hall Road 21701 United States 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. specify: White Completed 3 Nidowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) Electrician Explosives Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mentai marked ပ္ Frank Masaitis Tilly Yankauskas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Sandra Johnson 7907 Dance Hall Rd., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Importent: If its any injury or of once. cemetery, crematory or other place)
St. John's Cemetery 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/2/2012 Frederick, Maryland Name and Address of Facility eeney & Basford Funeral Home 06 E. Church St., Frederick, 21. Signature of Funeral Service Licensee 22. Name and Keeney 106. F MO1612 .06 E MD 21701 23a. Part 1. Sinter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumone disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): after death.

Director: After this cartificate has been signed by the attending physician and in by the truncing physician and in by the funeral director, page 2 should be deteched for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death? 2 N 1 ☐ Yes 2 ☐ No ☐ Yes of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural 5 Pending iniury work? Division 2 🗌 No Investigation fillad in by tha 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funeral Di complataly fillad in Medical 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 30. Name and address of person with pumpleted cause of death (Item 23a) (Type, Print) BX. MD Registrar's Signature filed (Month, Day, Year) 32. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ TOXIC 12:20 A M Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS 15 CYPRESS ROAD 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) If Under 1 Year **Funeral** Days (Month, Day, Year) 212-30-4620 Director 1 🛛 M 2 🗆 F 11/7/1932 JONESVILLE, VA 79 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State Examiner must be notified at Director 1 Yes 2 No MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō "natural", or items 23a 21403 UNITED STATES 15 CYPRESS ROAD Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE If Yes, Give Year or Dates. 1950 Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4 or 5+) PENAL SYSTEM CORRECTIONAL OFFICER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file.
Department of Health and Mental H
Important: If item 27 is marked oft
any injury or other traumatic aver-ပ LASSIE BOLIN TYLER MAXIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 CYPRESS ROAD, ANNAPOLIS, MD 21403 PAMELA MAXIE/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 10/1/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility ASTING TRIBUTES BY FELLOWS HELFENBEIN & NEWNAM CREMATION & FUNERAL CARE 814 BESTGATE ROAD, ANNAPOLIS, MD 21401 Signature of Juneral Service Li art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nterval Between nset and Death Immediate Cause (Final Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury use as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No been signed by the s should be detached 9 🗌 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page 2 Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medica filled in by the funeral director, Be Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 은 1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending Natural 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier person who completed cause of death (Item 23a) (Type, Print)

State Registrar 30. Name and address

31. Date filed (Month, Day, Year

OCT 01 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Sept. Corwin Alan Moore II 2012 1:50 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 566 Rich Mar Street Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country)
Georgia 8. Date of Birth **Funeral** 1 **X** M 2 □ F Hours Min (Month, Day, Year) uq 31, 1992 Director 253-85-8425 20 Aug Usual Residence of Decedent 23a or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Westminster 1 🗆 Yes 2 🗶 No Carroll Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 566 Rich Mar Street USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 No Black. White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 Widowed 4 Divorced white Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) School Student 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dara Southwick Corwin A. Moore permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 566 Rich Mar Street, Westminster, MD 21158 Corwin Moore, father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State All Faiths Crematory 9/22/2012 Manchester, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home -star 91 Willis Street, Westminster, MD 21157 83a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DEHYDRATER Medical Due to (or as a consequence of) Examiner Burge Y DAYS OUSTNU Cho Sequentially list conditions if any, leading to immediate cause. Enter Orderlying Cause (Disease or linjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transi 121000 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 Yes 2 No Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

after death e Funeral I within 2 To the I

completed မ

State

Registrar

DHMH 17 Rev 7/2009

Medical

29a. Certifier

only one) 29b. Signature and title of certific

CUAHO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

istrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CHARLES

29d. Date signed (Month, Day, Year)

ILANTINONE ZIZOY

#5105

ST

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month 15, 2012 2:50 a Clyde Clayton Mellema September 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carroll Lorien Nursing & Rehabilitation Ctr Taneytown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number Days Hours 1 M M 2 □ F 213-38-9688 71 Maryland 1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County Union Bridge 1 ☐ Yes 2 No Carroll Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21791 859 Star Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11 Marital Status Black White etc. 1 Never Married 2 Married 1 Yes 2 No white Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State Highway Elementary/Secondary (0-12) College (1-4or 5+) Administration Heavy Machine Operator 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Francis Volk Clyde Mellema 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 859 Star Court, Union Bridge, MD 21791 Ruth Mellema, wife 20b. Place of Disposition (Name of cemetery, crematory or other place)Grd 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 09/19/2012 Finksburg, MD Evergreen Memorial 4 □Donation 5 □ Other (3 to nb nent Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 91 Willis Street, Westminster, MD 21157 23a Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) etasta Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown NON 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760,

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this certificate has

After

death.

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or items 23a or 28a-f show the Mazical Exerciter must be notified at

27 is marked of traumatic even

Department of Health a Importent: If item 27 is any injury or other tra once.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

Be

Examiner

Physician/Medical Be Completed by Certification: To filled in by the

within 24 hours after death To the Funerel Director: To the

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only onel

investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

death (Item 23a) (Type, Print Rd. Westminstop 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

8 2012 SEP 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	-	partment of I		Mental Hy	giene		
			Registrar		С	ertificate of I	Death	T	Reg. No. 2	0/2	33421
	Physicia Medic		Decedent's Name (First, Middle, Last David A. Minnick Sr.				_	2. Date of De	ath Say	18°12	3. Time of Death 0940 / A M
	Examir	er	4a. Facility Name (if not institution, give			4b. City, Town, o	Cumbadan		4c. Count	y of Death	
	Funeral		5. Social Security Number 6. Sec		(In yrs. last birthda		Cumberlan If Under 24 Hrs.	8. Date of Bir	Allega		ace (State or Foreign
	Director		218-90-0194 Usual Residence of Decedent	X M 2 □ F	49 Yrs	Months Days	Hours Min.	(Month, Da Jun é	y, Year) 29, 1963	Countr Mary	y) .
	yland f shov ed at	ţō	10a. State 10b. County		10c. City, Town or					10	d. Inside City Limits
	e Mar r 28a- notifi	Director	Maryland Allegan		Frostburg						1 X Yes 2 □ No
	with th	Funeral	12010 Sa	and Bank Road		10f. Zip Code 21532-			10g. Citizen of U.S.A.	What Countr	y?
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status	12. Was Decedent Ev Armed Forces?		3. Was Decedent of H	lispanic Origin? (Sp an. Mexican, Puerto	pecify Yes or No-	14. Rac	ce - America	
036	s after ral", or Exami	ed by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 N If Yes, Give Year or Dates.	10	1 🗆 Yes 2 🗶 No		,	Specify	ck, White, et	
2-0	hour "natur	plete	15. Decedent's Ed (Specify only highest gra	ducation		cedent's Usual Occup		liter -	16b. Kind of B	White usiness/Indu	
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2	iled wi I Hygik other vent, t	Be	17. Father's Name (First, Middle, Last)	•	Out	ty WOIKEI	18. Mother's Nar	ne (First, Middle,		e)	
Maryland 21215-0036	Ild be f Menta Iarked atic ev	To	Allen Minnick				Mary Mire			~	
Mar	2 should th and Me ?7 is mark traumati	- 2	19a. Informant's Name/Relationship (T) Julie Minnick	vpe, Print) wife		iling Address (Street					
	f Health item 27 other tra		20a. Method of Disposition	WIIC	1	Sand Bank Ros	ad Fro	stburg Date	Mary 20c. Location		21532-
E O			1 ☐ Burial 2 🔀 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			rematory or other place and Crematory		er 10, 2012	Cumberla		ryland
Baltimore,	permit. Page Department of Important: II any injury or once.		21. Signature of Funeral Service Licens	ee		22. Name and Addre		Erost Ave	Egoethum	MD 21	522
			23a. Part 1. Enter the disease, or comp	olications that caused t	the death. Do not e	Durst Funer					Approximate
۸.,	Physician/	, , ,	shock, or heart failure. List only or Immediate Cause (Final disease or condition	(1)	mmie						nterval Between Onset and Death
	Medical Examiner		resulting in death)		consequence :						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence of):					-	
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_	cate be executed physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a	consequence of):						
20/2	icate by physics the l	ledical		d							
χ	n certif	an/N	Los. Trae decedent program	23c. If yes, outcome of	f pregnancy	☐ Ectopic pregnance	27		23d. Da	te of delivery	,
POX	requires that the death certific been signed by the attending I should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t 9 Unknown		Other (specify)		_	Мс	onth D	ay Year
ў. Э.	that th ned by e detac	by Ph	Part II. Other significant conditions co	ontributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did to	bacco use cont	ribute to the	cause of death?
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ĭ	n: The fficate or, pag		25. Was case referred to medical			00 5		1 🗆 Yes		death?	□ No
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101	ing Ph		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day,	28b. Time	of 28c. Injury	/ at	28d. Describe h			
DIVISION	Attend death ctor: A	ertificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		/ - At home farm s	M 1 🗆	Yes 2 No	005 1 (0		- 0 10	
2	tal or A	0	4 ☐ Homicide determined	building, etc.	(Specify)	areet, factory, office		City or Tow	treet and Numbe n, State)	er or Hural Ho	oute Number,
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 ☐ Medical Examir	ician: To the best of m	mination and/or inv	estigation, in my opinic	n, death occurred a	t the time date ar	nd place and due	to the cause	e(s) and manner stated
	To the within 2 romple		only one) 3 Certifying Nurs 29b. Signature and title of certifier	e Practitioner: To the b	pest of my knowledg	ge, death occurred at the 29c. License	he time, date and pl	ace, and due to the	ne cause(s) and n 29d. Date signed	nanner as stat	ted.
	10		Robit Jai	m MI)	D-7			10.08		
	nie		30. Name and address of person who co		ith (Item 23a) (Type	Print)	0 6 /				
,	Stat	e .	31. Date filed (Month, Day, Year)		Signature	probledi	Koad (cember	and n	10-	21502
	Registra	ır	31. Date filed (Month, Day, Year) OCT 0 9 2012	Deneus &	Signature	/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician/ HELEN VIRGINIA TWIGG MASON 8:20 P 201 10 05Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Cumber land Allegany The Golden Living Center 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 02/05/1918 Months Days Hours 1 M 2 XF 217-10-4172 94 **Director** Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at Directo Cumberland 1 Yes 2 X No MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 21502 13112 Williams Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates Specify: 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Naomi Andrews ည Raleigh E. Twigg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13201 Fifth Avenue, Cresaptown, MD Shirley Walbert / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD Zion Memorial Park 10/09/2012 4 Donation 5 Other (Specify) 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21. Signature of Funeral Service Lyense 21502 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Physician; The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-transity Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Pulm nal sede 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 No this certificate To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d, Describe how injury occurred or Attending (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined after City or Town, State) To the Hospital or within 24 hours aff To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifie The desired in the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie

State Registrar 10000

Carriagten Lour

Camberland, Md 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HALMOS

PETER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roy Alan Mollett Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death REGIONAL SALISHI TENINSULA Centu NICOMICO Medical If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. (Month, Day, Year) Country) Director 1 M 2 D F 12/19/1919 Oregon other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Md. Wicomico Salisbury 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 130 Village Oak Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 ☑ Yes 2 ☐ No 1942 Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩idowed 4 ☐ Divorced If Yes, Give Specify: 1946 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Communications Telephone Engineer 27 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mental be 1 Elizabeth Small Mollett Roy H. Mollett and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $31665\ College\ Back\ Bone\ Rd.,\ Princess\ Anne,$ 2185 . Page 1 and 2 st ment of Health a tant: If item 27 is Ted Mollett Son Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State cemetery, crematory or other place)
Salisbury Crematory -26-20/2 Salisbury, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 Princess Anne, 21853 Somerset 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Retw val Retwe Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) aus Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a c Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown sate has been signed by the a page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No ☐ Yes 2 🖟 N after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 11/10 ပ္ 1 Inpatient 2 DA/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signaty address of person who completed cause of death (Item 23a) (Type, Print) Registrar

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 26 2012 NARANJO 12:10pM DELIA Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Min. Director 566-45-6755 1 M 2 X F 57 July 20, 1955 Mexico Usual Residence of Decedent ir then "natural", or items 23a or 28a-f show the Medical Expriner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Walkersville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9382 Highlander Blvd. 21793 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 Specify: White 1 X Yes 2 ☐ No Specify: Mexican 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentel His marked of permit. Page 1 and 2 should be file Department of Health and Mentel Important: If Item 27 is marked of any injury or other traumatic eve ည Manuel Aguilar Matilde Medina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Tony Naranjo, Sr. 9382 Highlander Blvd. Walkersville, MD 21793 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of carnetery, crematory or other place)
Restnaven
Memorial Gardens Sept. Date 29, 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Cremer (Specify) 2012 Frederick, Maryland 21. Signature of Funeral Statice Licenses Restnaven Funeral Services, Skkot Cody P.A MD 21701 9501 Catoctin Mountain Hwy. Frederick, 23a. Part 1. Enter the disease, or shock, or hear failure. List mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death hly one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, il any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate hes been signed by the ettending physician and etely filled in by the funeral director, page 2 should be detached for use es the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 - Pending injury work? 1 ☐ Yes 2 ☐ No Accident Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D completely filled cal 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Type mysug mysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Cycl. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sastated.

Cyclifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number D65378 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar

State

31. Date filed (Month, Day, Year)

00

arks

400 W. 7th St. Frederick, MD 21701

611

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernard Joseph Ott III September 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Director 214-36-1489 69 1 X M 2 🗆 F Pennsylvania July 25, 1943 ed other then "naturel", or items 23a or 28a-f show event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Emmitsburg Frederick Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21727 19 Bunker Hill Drive USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. end Mental Hyglene. Is marked other then "naturel", or ģ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Completed 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Painting 12 Contractor Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bernard Ott, Jr. Evelyn Moose 1 and 2 should be of Health end Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Ott, son 9 Irishtown Road, Emmitsburg, MD 21727 20a. Method of Disposition
1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemeter) Scanding or other place) Date 20c. Location - City or Town, State permit. Page 1 a Depertment of H Importent: If ite eny Injury or ot 4 Donation 5 Other (Specify) 9/19/2012 Carroll Crematory Winfield, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 0 00 ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physicien and for use as the buriel-transit Hospitel or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day signed by the a d be detached t 1 ☐ Yes 2 ☐ No q Unknown 9 Unknown Records, P.O. Part <mark>II. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown s efter death. I **Director:** After this certificate has been signal of the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 1 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 1 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation To the Hospitel or Atterwithin 24 hours efter des To the Funerel Director completely filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K115108

10

Registrar

State

ucker

CRN?

4/702

516 Trail Ave Frederick

30. Name and address of person who completed cause of death (Item, 23a) (Type, Print)

SEP 1 8 2012

31. Date filed (Month, Day, Year)

Diane

32. Fegistrar's Signature

-07135 ephen Thoma	ıs Pa		e or Print in Bl te of Maryland							ible.	01	2 3343
		1- For State Registrar		Certif	icate of	Death				J. No.		
Physici adical Exam		Decedent's Name (First, Middle, Stephen The	,	tersor	n				Date of Death Month September		ear	3. Time of Death 1646 hrs
		4a. Facility Name (if not institution, Anne Arundel Medical ()		4b. City, Town, Annapolis				4c. County Anne A		
Funeral				ge (In yrs. last	birthday)	If Under 1 Y		er 24Hrs.	B. Date of Birth			nplace (State or
Director			1X M 2 F	49	Yrs	Months D	ays Hours	Min.	2/9/1	963	Foreigr Cou	ntry) LA_
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Locat	ion						10d. Inside City Limits
* .	ō	MD Balti	more	Ha	ampst							1 Yes 2 No
FROFE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nors of Health and Mental Hyggiene. and: If item 27 is marked other than "matural", or items 23a or 28a-f sho nor other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 19250 Resh I	Mill Road			10f. Zip Code 210				g. Citizen of W JSA	Vhat Coun	try?
ath with items 23	Funeral	11. Marital Status 1 Never Married 2 X Mar	12. Was Decedentied Armed Forces	?		s Decedent of es, specify Cul					ce - Americ ite, etc.	an Indian, Black,
after de al", or i	by Fu		ced If Yes, Give Year or Dates:	X No		Yes 2 X				Specify:	· wh	nite
hours 'natur		 Decedent's Education (Specific Elementary/Secondary (0-12) 	y only highest grade cor			nt's Usual Occu lost of working				16b. Kind of B	Business/In	dustry
5-0036 led within 72 hou tygiene. other than "nat	Completed	Elementary/Secondary (0-12)	2	34)	m	achin	ist			FDA		
5-0C led wit Hygien other		17. Father's Name (First, Middle, L	ast)				1B.Mother		irst, Middle, M	aiden Surnam		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica) Be	Gregory John 19a. Informant's Name/Relationshi			40h Mailin	g Address (St			a Anne			7:- Code)
nore, MD 2121 ggs: I and 2 should be fi nt of Health and Mental I t: If item 27 is marked other traumatic event,	ဥ	Donna M. Pa		1	· ·	,						MD 21074
ore, MD ss I and 2 sho of Health and If item 27 is the traumati		20a. Method of Disposition	·	20b. Plac		ition (Name of		D	Date	20c. Location		
Pages lent of unt: If		1 Burial 2 Cremation 4 Donation 5 Other Spe		Cari	roll	Crema	tion	9/2	5/12	Hamps	stead	d, MD
Baltimore, MI permit. Pages I and 2 s Department of Heath a Important: If item 27 injury or other traum		21. Signature of Funeral Service L	censee	M00741	1	Name and Addr		EI.	ine Fu			
Physician	_	23a. Part I. Enter the disease, or co	omplications that caused	d the death. Do	93 not enter t	4 S. I	Main	Stree	et, Ha	impste	eart	MD 21074 Approximate Interval
/Medical Examiner		failure. List only one cause o Immediate Cause (Final disease or condition resulting in death)		3								Between Onset and Death
		Sequentially list conditions,	b									
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a cons	sequence of):								
ed nsit	Examiner	events resulting in death) Last	Due to (or as a cons	sequence of):			•					
e executed cian and rial - trans	ical	UNPENDED	d AMENDED									
760 ficate b g physi	//Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregnan		etal death	3 Ectopic	c pregnance		23d. Date of		ay Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Med	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant a	t time of death	- ==	ther (Specify)		o pregnanc _i	, 	Worth		ay rou
b.O. Be that the de red by the detached fi		Part II. Other significant condition	ns contributing to deal	th but not resu	lting in the u	underlying caus	se given in Pa	art 1.			_	he cause of death?
S, P uires th n signe Id be d	ed by					_				2 ✔ No 3		
Vital Records, P.C. hysician: The law requires that this certificate has been signed al director, page 2 should be dete	Completed								24a. Was a autops perforn	у		opsy findings available ompletion of cause of
Rec : The ificate r, page		25. Was case referred to medical				26.01	ace of Death	(Charle and	1 Yes 2	No	1 Yes	2 No
/ital /sician uis cert directo	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2 🗸 EF	R/Outpatient		Othor	· ·		Residence 6	Other:	
n of \ding Phy. After the funeral	-	27. Manner of Death	2Ba. Date of Inj Month, Day, Sep 21, 2012	ury 28 Year)	3b. Time of I	Injury 2Bc. I	Injury at Work		3d. Describe he			
ision Attendi	atio	1 Natural 5 Pendir 2 ✓ Accident Investi	gation		000 hrs		Yes 2 ✓	No				
Divis	Certification:	3 Suicide 6 Could determ				et, factory, offic	ce building, et		or Town, St. or Town, St. 97 south at			al Route Number, City
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i		4 Homicide	sician: To the best of n			rred at the time	, date and pla					
To the How within 24 h To the Fur	Medical	one) 2 Medical Exam	iner:On the basis of exa	amination and/		tion, in my opir	nion, death oc			nd place, and	due to the	cause(s)
	ž	29b. Signature and title of certifier		, (A		ense number			29d. Date sig	·	
Ly C		well	M	1)	4	0.	C.M.E.			Septembe	er 22, 20	712
3		30. Name and address of person was Zabiullah Ali, M.D. A	ho completed cause of ssistant Medical E			Baltimore S	treet, Balt	imore, M	ID 21223			
	tate	31. Date filed (Month, September)	6 201232. Registra	ar's Signature	B. 14	barker						
Regis	trar	OLI 3			1. 0	127-						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Day 9, Physician/ Pearl Madolene Peller 2012 3:30 p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Finksburg 1923 Deer Park Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 2, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 - M 2 X F Days ^{Year)} 1938 74 212-36-3096 Yrs Maryland **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location death with the Maryland notified at 10d. Inside City Limits Director Finksburg Carroll 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code and Mental Hygiene. 'is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be r 10g. Citizen of What Country? Funeral 21048 1923 Deer Park Road USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify. Completed white 3 ¥ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Store Cashier 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is many injury any injury and injury ည Madolene Wood Clarence W. Meekins, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 63 N Prospect Ave, Catonsville, MD 21228 Dr. Andrew Walther, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crest cremawn other place) 9/24/2012 Memorial Gardens Marriottsville, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 and Death Immediate Cause (Final Ph sician/ a month disease or condition Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to infimediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). Exami burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be a thin 24 hours after death. the Cartificate has been signed by the attending physicial the Funeral Director: After this certificate has been signed by the attending physicial. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death signed by the a Unknown Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 autopsy Yes 2 No 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 'Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud 716

Registrar

State

31. Date filed (Month, Day, Year) SEP 2

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30,2012 MORY Medical Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 7. Age (In vrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 139 32 7683 71 Director 1 🕅 M 2 🗆 F 1/14/1941 NJor 28a-f show a notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 601 Twin Tree Rd. 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married by 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) systems analyst self employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marie Gerone Louis Rothstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Twin Tree Rd. Ocean City, MD 21842 Sheila D. Rothstein 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State First State Crematory 10/2/2012 Millsboro, DE Other (Specify) 4 Donation 5 D 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Phy ir ian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death g Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autops performed 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: after death. Director: After (Month, Day, Year) Natural 5 Pending 2 No 1 Yes Investigation
6 Could not be 2 Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by ☐ Homicide determined within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Registrar's Signature State 2

Registrar

12-07288 Charles Lloyd R		State of Maryland / Dopartment of Flediti and Men	
Dhi.:i		1- For State Certificate of Death 1. Decedent's Name (First, Middle,Last)	Reg. No. 2. Date of Death 3. Time of Death
Physicia Medical Exami		Charles Lloyd Robbins	2. Date of Death Month Day Year September 26, 2012 3. Time of Death 1355 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location	
		Memorial Hospital of Easton Easton	Talbot
Funeral Director		Months Days Hours	er 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Birector		219-03-4467 1XM 2F 90 Yrs.	Nov. 15, 1921 Country) MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit
and show nce	5	MD Dorchester Cambridge	1 X Yes 2 N
Maryland 28a-f sh	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
death with the Maryland or Items 23a or 28a-f abo		402 Oakley Street 216	
ath wi	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 X Married 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	
fter de		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	specify: white
ours a atura	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give	kind of work done 16b. Kind of Business/Industry
16 n 72 h nan "n	ig e	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT	
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21 nould bed is mar	흔		nber or Rural Route Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a in Injury or other traumantic event, the Medical Examiner must be notif			Rd., East New Market, MD 21631
Ore, of He Lite		1 X Burial 2 Cremation 3 Removal from State crematory or other place)	Date 20c. Location - City or Town, State
ti Pag rtment rtant:		4 Donation 5 Other Specify: Old Trinity Churchyard 3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3-3	
Bal permi Depa Impo	ł	700 Locust St.	Thomas Funeral Home P.A., Cambridge, MD 21613
Physician	寸	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cafailure. List only one cause on each line.	ardiac or respiratory arrest, shock, or heart Approximate Interva
/Medical Examiner		Immediate Cause (Final disease a. Complications of right hip fracture	Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	
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BO) e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown	
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Records, P.O. I The law requires that the cate has been signed by the page 2 should be detached.	bet	Heart Disease; Diabetes Mellitus; Dementia	1 Yes 2 ✓ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
COFC law re has be	Completed	-	autopsy performed? death?
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ion ttendi leath. tor: /	aţio	1 Natural 5 Pending Sep 25, 2012 2035 hrs 1 Yes 2 ✔	No Subject fell
Jivis Il or A after d in by	Certification:	3 Suicide 6 Could not be determined (Specify) Single Family Home	or Town, State)
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Cartifier Physicals Table and Cartifier 1	1002 Manon , Stevensville, MD
To the H within 24 To the F complete	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occ	
To Mit.	Me	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
5		O.C.M.E.	September 27, 2012
i i	}	30 Name and address of person who completed cause of death (Item 23a)	
	ate	30 Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltim 31. Date filed (Month, Day, Year) 32. Registrar's Signature	nore, MD 21223

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 09 Marion E. Simpson ^{Day}25 2012 Physician/ 11:05P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday, **Funeral** Hours 217-44-2381 **Director** 85 1 DM 2 X F ebruary 3,1927 Anne Arundel Usual Residence of Decedent than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Odenton MD Anne Arundel 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1546 Meyers Station RD 21113 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced Specify: White Year or Dates nit. Page 1 and 2 should be filed within 72 hours artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natur injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry U.S. Deparment Of (Specify only highest grade completed) Elementary/Secondary (0-12) Research Scientist Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John T. Simpson Sr. Emma Meyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Holman 1744 Mayapple Way Gambrills, MD 21054 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State riade of bisposition (Name of cemetery, crematory or other place)
First Lutheran 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/02/2012 | Bowie, Maryland Church Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home, 21. Signature of Funeral Service Licensee Lui 1G 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) meumoni Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): sician a Physician/Medical Division of Vital Records, P.O. Box 68760 physi the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
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e Funeral Director: After tholetely filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 6 Could not be Accident 3 Sulcide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Funel

completely fi 29a. Certifier Prtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

0 1 2012

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Epton by Bay Year Swift 54 onnie AM 2017 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bultimore Hospita The Johns Hopkins Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 214-68-7488 53 1 🗶 M 2 🗆 F March 5, 1959 Maryland "natural", or items 23a or 28a-f show edical Examiner must be notified at be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26546 Mariners Road 21817 USA 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) nd Mental Hygien marked other th 12 5+ Accountant Somerset County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Donald Lee Swift Mary Virginia Hinman permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Lee Swift (Father) 26546 Mariners Road - Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Sunnyridge Memorial Park 10/05/2012 Crisfield, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ iver disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial: Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year Yes 1 ☐ Yes 2 ☐ g ☐ Unknown g Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 s certificate has director, page 2 autopsy performed Yes 2 No death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No I Director: A Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a To the Funeral Completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEVEN mo40 1800 Ocleans St. Baltimore UPZIZ87 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na		(Type, Print)		19b. Ma	ling Addres	s (Street a			I Route Numb	er. City o	or Town. Sta	ite. Zin (Code)	_
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the bu	cal C	29a. Certifier 1	H Cortifuing B						-1-11		City or Tov					_
ne Hos in 24 hr ne Fun pletely	Medical	(Check 2		hysician: To the b miner: On the bas urse Practitioner	is of examinati	ion and/or inve	stigation, in	noinigo vm	 n. death oc 	curred at	the time, date a	and place	e, and due to	the car	ise(s) and manner sta	ated
To the Vithing the Community of the Comm		29b. Signature and t		00.				. License					ate signed (/			
	-	30. Name and addre	ss of person wh	e completed cours	e of death /lto	om 23a) (Tupo	Print1	US.	2711	9			7/2	111	7	_
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Stat	е	31. Date filed (Month	CED 9 8	2012 32. R	gistrar's Sign	ature 6	1	,		a		19				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ . 2012 MARGARET FAYE SPACEK Month 2:50 P SEPT 28 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WILLIAMSPORT HOMEWOOD AT WILLIAMSPORT WASHINGTON 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours TEXAS 464-26-8118 Director 88 1 M 2 X F 1/23/1924 28a-f show within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location MARTINSBURG 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director BERKELEY W۷ 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25405 Funeral 60 MYRIAH DRIVE USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. \$ 1 ☐ Yes 2 X XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ YNo Specify. WHITE 3 Widowed 4 Divorced Completed Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) iould be filed within 72 | nd Mental Hygiene. marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MAMIE ROBINSON LOUIS DILLARD BUCHANAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANK J. SPACEK, JR./SPOUSE f Health 60 MYRIAH DRIVE, MARTINSBURG, WV 25405 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite 20c. Location - City or Town, State 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PLEASANT VIEW MEM. PGDS. MARTINSBURG, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, any 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of jach line. Approximate al Between Immediate Cause (Final Physician/ A SOLDAN SGRE disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year ned by the a e detached f 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? 2 been signe should be o Records, Completed 1 Yes 2 No 3 Probably 4 Unknown (XTacni 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 2 No To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifica of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🗹 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29d. Date signed Month, Day, Year) MEDICAC 0/2

Registrar
DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ 1718 PM JoAnn Thompson SEPTEMBOR 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Mertius Medical Center . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Hours Min. Davs **Director** 214-36-0519 1 🗆 M 2 🕱 F 73 June 5 1939 Maryland or 28a-f show e notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director Frederick Brunswick 1 X Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 317 East "D" Street 21716 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 0. Black White etc. þ 1 Never Married 2 3 Married 1 Yes If Yes, Giv 2 XNo Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", Specify: Completed 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Farmers & Mechanics Elementary/Secondary (0-12) College (1-4 or 5+) Bank 12 Bank Teller Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall Joseph Barger, Sr. Elsie Mae Flook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si of Health a item 27 i 317 East "D" Street, Brunswick, MD Jesse L. Thompson, Husband other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/29/12 Hagerstown Crematory Hagerstown, MD 21. Signature of Funeral Service Uce 22. Name and Address of Facility John T. Williams Funeral Home 100 Petersville Road, Brunswick, 21716 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physiciani ARRYTHMIA disease or condition resulting in death) Medical Examiner FIBRICATION MONOUS Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed ATHERW SCEROTIC (Ant)10 VAS COLLAR the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical menter TO LUNGS MAD BONES MOTHS MAIC BROWST CANCER Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page performed Yes 2 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes ျ 1 Inpatient 2 FR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 Matural 5 Pending nours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MI law

Registrar

State

G/HAZALA

31. Date filed (Month, Day, Year)

KOAD

(THEISUS TOWN

MAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V

1190

MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Heartlands Assisted Living Ellicott City Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Director 220-28-3902 1 M 2X F 84 9/20/1928 Usual Residence of Decedent I Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City MD Howard 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3020 North Ridge Rd. # 403 21043 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: 3€Widowed 4 □ Divorced Specify: white Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) teacher Balto. Co. Schools Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked oth 18. Mother's Name (First, Middle, Maiden Surname) ပ္ unknown Carrie A. Anthony 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3010 N. Ridge Rd., Apt C505, Ellicott City 19a. Informant's Name/Relationship (Type, Print) Estelle Marsel, Pers. Rep. 20c. Location - City or Town State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1
Department of I
Important: If it
any injury or or Hampstead Cemetery 9/29/2012 Hampstead, MD 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses MO074122. Name and Address of Facility Eline Funeral Home 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin that the death certificete be executed burial-transit Cause (Disease or hijur that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 use as the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by within 24 hours after death.

To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy or Attending Physician: The 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to hedical æ Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowled To the within 2 e and address of person who completed cause of death (Item 23a) Type, Print)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			and Ottale	Maryland / Depa			lental Hy		
1			Registrar 1. Decedent's Name (First, Middle, Last)	Cei	tificate of De	eath	0.01.15	Reg. No. 2) 2 3344
	Physic Med			s Testerman			2. Date of De Month	ber 22,	Year 3. Time of Death
	Exam	iner)	4b. City, Town, or Lo		bepten	4c. County	
	Funera		Golden Living Center 5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)		inster Under 24 Hrs.			arroll
	Directo	_	220-28-2789	79 Yrs.		Hours Min.	8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)
	land show d at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation		Dec 24	, 1932	Maryland
	Maryla 28a-f	Director	Maryland Carroll			stminste	r		10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th the 3a or t be n		10e. Street and Number 1234 Washington Road		10f. Zip Code			10g. Citizen of W	
	eath w	Funeral	11. Marital Status 12. Was Deceden	Everint S 42 W	/a. Daniel I. (Uli	21157			USA
36	after de	6	1 Never Married 2 Married Armed Forces	? TNo	/as Decedent of Hispa Yes, specify Cuban, M	nic Origin? (Spec flexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race Black	- American Indian, , White, etc.
00	atural	eted	3 Widowed 4 Divorced If Yes, Give Year or Dates.		☐ Yes 2 X No S			Specify:	white
215	in 72 he. e. nan "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or	(Give k	ent's Usual Occupation ind of work done during NOT use retired)	n I g m ost of workin	g	16b. Kind of Bus	siness/Industry
2	d with Hygien Ither ti	Be C	8 17. Father's Name (First, Middle, Last)	Mi.	llworker			Manu	facturing
lan(l be filk fental l rked o	10	Lester Testerman		18.	. Mother's Name	(First, Middle, I Damewoo	Maiden Surname)	
Jary	should and M is ma auma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Address (Street and N				ith. Zin Code)
e,	and 2 Health tem 27 ther tr		Dorothy Testerman, wife 20a. Method of Disposition	520 5	remont Dr	, Apt 11	, Westr	ninster,	MD 21157
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		1	20b. Place of Disposicemetery, creme Pipe Creel	atory or other place)	9/26/			City or Town, State Bridge, MD
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licensee	22.	Name and Address of Willis St	Facility Mve	rs-Durt	oraw Fur	neral Homo
			23a. Part 1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin	d the death Demis	the mode of dying, suc	ch as cardiac or	respiratory arre	st, MD	Approximate
Japan,	Physician/ Medical		Immediate Cause (Final	vovascula	Acard	0-+			Interval Between Onset and Death
1	Examiner		Due to (or as	a consequence of):					4 WELKS
	n #	iner	occidentially list conditions,	a consequence of):	^ .				6 years
	ate be executed oblysician and the burial-transit	Examiner	that initiated events c.	osclenot da consequence of):	: Landrov	ras cul	ac D	SANSA	25 years
09,	ate be execu	edical	d d	a consequence oi).					,
6876	rtificat ing ph e as th	Med	IF FEMALE:						
Box 6	eath certifica attending p	cian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome 1 Live Birth	2 Fetal death 3 E	ctopic pregnancy			23d. Date of	
). B	Hospital or Attending Physician: The law requires that the death certific 4 hours after death. Funeral Director: After this certificate has been signed by the attending it tely filled in by the funeral director, page 2 should be detached for use as	Completed by Physician/M	1 Yes 2 No 4 Pregnant a 9 Unknown 9 Unknown		Other (specify)			Month	Day Year
, P.O.	v requires that been signed to should be deti	by	Part II. Other significant conditions contributing to death b	ut not resulting in the und	erlying cause given in	Part I.	23e. Did toba	acco use contribu	te to the cause of death?
ords	requir been s should	etec	Advanced Age				1 🗆 Yes	s 2 No 3 l	Probably 4 Unknown
Records,	he law te has l age 2 s	dwo					24a. Was an autopsy perform	/ prio	e autopsy findings available r to completion of cause of
ial	ysician: The la is certificate ha director, page		25. Was case referred to medical examiner?		26. Place of	Death (Check on	1 Yes 2	No 1	Yes 2 No
of Vital	Physic this ce	ှု ရ	1 ☐ Yes 2 ☒.No Hospital: 1 ☐ Inpatie	ent 2 ER/Outpatient	Other			ice 6 Other (S	Specify)
o uc	ath. :: After ie funer	Certificate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injur (Month, Day	Year) injury	28c. Injury at work?	28d		injury occurred	
Division	al or Attendir s after death. Il Director: Af ed in by the fu	ertif	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Inju	ry - At home, farm, street.	M 1 ☐ Yes 2 factory, office		Location (Stre	et and Number of	Rural Route Number,
Ö	spital or ours afte eral Dire		building, etc				City or Iown,	State)	
	the hin the	Med	29a. Certifier (Check only one) 3 Certifying Physician: To the best of responsible to the control on the control one only one) 3 Certifying Nurse Practitioner: To the	ny knowledge, death occi amination and/or investigat best of my knowledge, dea	urred at the time, date tion, in my opinion, deat ath occurred at the time	and place, and d th occurred at the , date and place,	ue to the cause time, date and and due to the	e(s) and manner a place, and due to t cause(s) and mann	is stated. the cause(s) and manner stated. er as stated.
	S in the second	2	9b. Signature and title of certifier	RNA	29c. License numb	er	290	d. Date signed (Me	onth, Day, Year)
	C	3	Name and address of person who completed cause of de	ath (Item 23a) (Type Print	R0497	07	0	9 24	2612
	4		PACLOUGHING HEARN 6881		ID WEST	แมรช่า	RMD	2115	7
	State Registra		1. Date filed (Month, Day Year) 2 5 2012 32. Registrar	's Signature		v - v v			
DUM	11.47.5			- 10. 14					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend 19b per FD, DOR, Registrar 10/5/12,LDB Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death September 26 2012 Physician/ Reginald Paul Todd 7:40 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours Director 180-14-1222 87 1 🔀 M 2 🗆 F Dec. 16, 1924 Maryland Usual Residence of Deced 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified MD 28a-f East New Market Dorchester 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a 5739 Mt. Holly Road 21631 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Examiner ò Completed by 1 Never Married 2 Married X Yes 2 No Yes, Give τ.π. Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after han "natural", i Medical Exan 1 Yes 2 X No Specify: white Year or Dates. WWII 3 🙀 Widowed 4 🗌 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. alth and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Secondary (0-12) College (1-4 or 5+) home improvement painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Florence Bradford Sangston Todd 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 421 Oakley Street, Cambridge, MD 21613 Glenda Wroten daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other placel East New Market Cem. | 9/30/12 4 Donation 5 Other (Specify) East New Market, 22. Name and Address of Facility Thomas, Funeral Home P.A. ature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ acute myocardial infarction Medical **Examiner** vascular disease 20 years ath levosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or injury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ in the past 12 months? Month Day Year ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Cardiomyopathy Completed 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? this certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\text{Yes} \) 2 \(\text{No} \) No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide after To the Hospital within 24 hours a To the Funeral C Medical Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

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Examin		4a. Facility Name (if not institution, give s	e Megli	02 6	enter			Location of E	Wol		4c. Count	VICON	nico
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Mary 28a-f	Director	VA ACCOMAC	ζ	SA	XIS								1 X Yes 2 No
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Illed v illed v lothe vent,		17. Father's Name (First, Middle, Last)								(First, Middle, M	laiden Surnai	ne)	
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re, Marylania Z IZIS-COOO 1 and 2 should be filed within 72 hours after deeth with the Maryland 4 health and Mentel Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumetic event, the Model Examinar must be notified at		19a. Informant's Name/Relationship (Ty DORIS WATKINSON								Route Number, 146 – SA			
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Daltimore permit. Page 1 a Department of H Important: If ite any injury or oth		21. Signature Funeral Service Licens						ss of Facility			FUNERA		
D SQEES		Carl as	CARL U		RNTQN							PARK	SLEY, VA
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Division of Vital Reco To the Hospital or Attending Physician: The lew within 24 hours effer death. To the Funerel Director: Affer this certificate has I completely filled in by the funeral director, page 2	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of I	njury - At h etc. <i>(Specif</i>		treet, factor	y, office			28f. Location (Si City or Town		nber or Ri	ural Route Number,
Spital hours of nerel I	Medical	29a. Certifier 1 Certifying Phy	sician: To the best	of my knov	vledge, death	occurred a	t the tim	ne, date and r	olace, a	and due to the ca	use(s) and m	anner as s	stated.
the Ho in 24 the Fu	Med	(Check 2 Medical Examonly only only) a Certifying Nur	iner: On the basis o se Practitioner: To	examination	on and/or inve my knowledg	e, death oc	urred at	the time, date	and pl	ace, and due to the	ne cause(s) an	d manner	
To the within 2 comple		29b. Signature and title of certifier	h_m			29		se number	10		29d. Date sig	ned (Mon	th, Day, Year)
CH		30. Name and address of person who	Z	donth fit-	m 23a) /Tim-	Print\	1016	1600	10		10	1/00	
141		30. Name and address of person who			arvoll		S	1653	u	7 MO	2/3	108	
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State of Maryland / Department of Health and Mental Hygiene 2012 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Woolard Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS- RMC Cumberland Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country Sep 24, **Director** 217-18-4465 1 M 2 X F 1921 91 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Allegany Cumberland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 Seton Drive 21502 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 Married J Yes 2 ₺ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced white Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>homemaker</u> own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Cecelia Elizabeth Monahan Walter Wade Cook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Woolard 913 Hilltop Drive SW MD 21502 son Cumberland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Crema tion 3 Removal/from State Hillcrest Memorial Park 10/12/2012 4 Donation 5 Other (Spenify) Cumberland MD 21. Signature 22. Name and Address of Facility Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ anduminua disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) signed by the attending physician and defected for use as the burial-transit Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. -23e. Did tobacco use contribute to the cause of death? ò To the Functional after death.

To the Funeral Director. After this certificate has been significated to the Funeral Director. After this certificate has been significant for the Funeral director, page 2 should I 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ျှ 1 🗌 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA Medical Certificate: 27. Manner of Death 28c. Injury at 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 072514 10, 9, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Willowbrook Rd Cumberland, MD, 21502 12500 31. Date filed (Month, Day, Year)

OCT 11 2012 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harold Bruce Webster 0717 AM Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SALISHU NICONIA ODIONAL adiron Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Days Hours Month Day, Year) 50 Maryland Director 1 € M 2 🗆 F 216-56-1452 61 28a-f shov 10b. County Somerset 10c. City, Town or Location Deal Island 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 ⋤ No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country?
United States 21821 23a 10140 Deal Island Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ŏ à 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Seafood Waterman other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jennie Horseman Webster William Edward Webster should be and Is m 19a Informant's Name/Relationship (Type, Print) Lean Webster Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health an Important: If item 27 is a any Injury or at 21821 10140 Deal Island Rd., Deal Island, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Peter's Cemetery 9/27/2012 Oriole, Md. 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licenses Princess Anne, Md. 21853 M00295 11673 Somerset Ave. 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ase or condition Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last eral Director, After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical 68760 IF FFMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Z No 1 Inpatient မှ ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept. 2012 SUSAN **EVANS** 22° WILLIAMS 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26446 Mariners Road Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month, Day, Year) **Director** 92 120-07-1933 1 M 2 X F Yrs. March 16, 1920 Maryland Usual Residence of Decedent الygiene. I other than "natural", or Items 23a or 28a-f sho vent, the Medical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Somerset Crisfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26446 Mariners Road 21817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Yes 2 No 1 Never Married 2 Married Black, White, etc. δ Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Home Maker Own Home Be other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fis marked o t. Page 1 and 2 should be fill trinent of Health and Mental tant: If item 27 is marked ည Herman Evans Lily Marsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John E. Williams (Son) 25 Long Pond Drive - Nantucket, Massachusetts 02554 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 XBurial 2 Cremation 3 Removal from State Sunnyridge Memorial Park 10/13/20/12 Crisfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Addition of Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, Maryland 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death ✓ Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the direction that the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year be detached 9 Unknown Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed this certificate 1 Yes 2 No 2 N Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Residence 6 Other (Specify) No No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manper of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 1) 63199 27/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOHRA 910 EASTERN SHORE OGESH SALISBURY MD 31. Date filed (Month, Day, Year) SEP 2 8 2012 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** EIMER AMURRI 1137 PM October 15 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral X** M 2 □ F Months Days Hours Min 155-07-1327 Pennsylvania 90 December 2,1921 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2X No Maryland Baltimore Dundalk Directo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? death with 1733 Melbourne Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. be filed within 72 hours after on that Hygiene.
It other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: White 2 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Steel Crane Operator 10 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Philip Amurri Sancta Ezzi မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Freeman Daughter 2804 Southbrook Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 17 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 line 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asytole disease or condition resulting in death) /Medical Due to as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and d for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 2 ☐ No 3 ☐ Probably 4 🖼 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 2 No 1 ☐ Yes 2 ☐ No 1 TYes or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Hospital 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) ၉ after death.

Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident the 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital 24 hours Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completely f Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hor 32. Registrar s Signature

Jonathor

31. Date filed (Month, Day, Year)

720344732 October

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Joseph T. Avara 10-14-2012 Medical 9:10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6135 Cardiff Avenue Baltimore
If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours Director 213-34-7559 1 € M 2 □ F 74 11-16-1937 . Page 1 and 2 should be filed within 72 nows comments of Health and Mentel Hygiene.
Thent of Health and Mentel Hygiene.
Thent: If Item 27 is marked other than "Instural", or Items 23a or 28a-1 show thent: If Item 27 is marked other than "Instural", or Item 27 is marked other than "Standing at Item 27 is marked other than "Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6135 Cardiff Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. \$ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Civil Construction 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vince Avara Marie Avara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Avara Wife 6135 Cardiff Avenue Baltimore Maryland 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of I importent: If its any injury or ot once. Date 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Cother (Specify) 10-19-2012 Sac. Hrt. of Jesus Dundalk, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk, PA 7110 Sollers Point Road Dundalk, MD 21222 Mar M01176 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SCHEMIC Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): attending physicien and I for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Pregnant at time of death Month To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funsral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) OSCH Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, ed at the time, date and place, and due to 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 7200 State 1 8 2012 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10 10 Day 2012 Allen 11:07a .M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5782 Yellow Rose Ct. Columbia Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) Director 267-74-6625 1 □ M 🌂 🗆 F 64 Yrs. 04 11 48 FL the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Howard Columbia 1 Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 5782 Yellow Rose Ct. 21045 U.S.A. Page 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Homemaker House Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Fishers of the second ည Theodore Trent Lois Sapp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Krystal Lighty-Daughter 5782 Yellow Rose Ct., Columiba, Md 21045 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5 = 6 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Department or Important: If any injury or 4 Donation 5 Other (Specify) unset Memorial 10/15/2012 Pennsauken, NJ Signature of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 3a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Friysician/ TROKE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 YEARS HYPERTENSION Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) nding physician and use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be ed by the attending getached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ e e SCH ITUZOPHRENIA cate has been siç ; page 2 should b Completed 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has autopsy performed 1 Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 🗌 Yes 2 🛮 No 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.
Funeral Director: After this etely filled in by the funeral of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one)

P.O. Box 68760 Division of Vital Records, Medical within 24 ho

To the Fune

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number LEICHTLING MS DAVIO OCTOBER 11 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE COLUMBIA KNOLL 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AROLE ANDERSON 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death POWERSACK RETHABILITATION Lutherville Baltimore . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 220-36-3789 (Month, Day, Year) Days Hours Min. Director 1 □ M 2 X F Maryland 71 5/29/1941 ed other than "natural", or iteme 23a or 28a-f show evant, the Medical Examinar numbe notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Monkton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16113 Markoe Road 21111 U.S.A. 72 hours efter death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2x No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) parmit. Page 1 and 2 should be filed within 72 Dapartment of Heelth and Mental Hygiane. Important: If Itam 27 is marked other than any injury or other traumatic evant, the Magnical Bonce. Elementary/Secondary (0-12) College (1-4 or 5+) <u>aborato</u>ry Technician Medica1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Agatha Rapsardi Thomas Carroll Beach, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Anderson, Sr./husband 16113 Markoe Road Monkton, Maryland 21111 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2012 | Timonium, Maryland Dulaney Valley Mem. 21. Signature of Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) STAGE IV MEMSMAC BRUAST CANCER Medical Due to (or as a consequence of): Examiner G MOW. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attanding physician and I for use as tha burlal-transit Hospital or Attending Physician: The law requires thet the deeth certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was de 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month ate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this cartificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this a completaly filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Work: 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and/or inventioning in the cause of examination and or inventioning in the cause of examination and/or inventioning in the cause of examination and or invention and or inventioning in the cause of examination and or invention and or inve 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of confife 29c. License number 29d. Date signed (Month, Day, Year) 10-15-12 029301 Power who completed cause of death (Item 23a) (Type, Print) MIE TULLY therville 208 31. Date filed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Sarah Ann Brown Medical October 11 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Washington Adventist Hospital **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 250-84-0293 Months Hours Min (Month, Day, Year) Director 65 1 □ M 2 🔏 F June 25, 1947 SC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MDPrince George's Jpper Marlboro XI Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13001 Cloverly Drive 20774 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. <u>ج</u> 1 Rever Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electronic Quality Control Specialist Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Brown Janie May Curbeam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latricia B. Debnam 13001 Cloverly Drive, Upper Marlboro, MD 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place Cremation Center of MD October 22, 2012 Hanover, MD 4 Donation 5 Other (Specify) Signature J. Funda Service Licensee 3 Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Avenue, Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death 99 Medical resulting in death) Due to (or as a consequence of): Examiner an col Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months
1 Yes 2 W No
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Pregnant at time of death Month Dav Year To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 2 🗆 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No ည 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 24 hours after deat Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20060120 MO 10-11-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aldmino 13000

State Registrar DHMH 17 Rev 06-2011 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Cornella Year DOSKULL UCTOBER 906 Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death BALTIMORE WASHINGTON MEDICAL ARUNDEL BURNIE ENTER (OLEN Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Director** 329-14-2133 1 □ M 2 🛛 F Usual Residence of Decedent 91 Sept. 12, 1921 0klahoma 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland | Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1602 Redhaven Court 21144 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married þ Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Manager Hotel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Joseph Rogers Mary May Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. <u> John E. Skasick / Son</u> 1602 Redhaven Court Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State October 0 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 2012 Odenton, Maryland Signati e o / v eral Service Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Preumonia Sequentially list conditions, Examine dany, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence on). ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 \ll Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has performed? Yes 2 No Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier Die earn 11753000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

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Hospital Drive,

20161

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g932 10-25-12 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DONALD Month BUSKIRK OCTUBER 3.53 A-M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEDSTARIHARBOR HOSPITAL BALTIMURE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours 311-38-0975 1 🖾 M 2 🗆 F 76 Sept.28,1936 Indiana Usual Residence of Deceder 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 164 Dunlap Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Brick Maker Masonry Harley Harvey Buskirk 18. Mother's Name (First, Middle, Maiden Surname) Doris Rawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Buskirk / Son 164 Dunlap Road Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 $\overline{\mathbb{X}}$ Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem.Park |Oct.16, 2012 Glen Burnie, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE disease or condition resulting in death) Due to (or as a consequence of) PULMONARY CHRONIC OBSTRUCTIVE DISTEATE Due to (or as a consequence of) equence of): 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ etal death Pregnant at time of death Month Year Day 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENAL DISEASE CHRUNIC 1 Yes 2 No 3 Probably 4 Number LEGS 0 / THE

Physician/ Medical Examiner Examine sician and burial-transit

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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Department of He Important: If he any infor-

other traumatic ge 1 and 2 should but of Health and Mer

Baltimore, Maryland 21215-0036

Sequentially list nonditions if any, leading to immediate cause. Enter Underlying

that initiated events resulting in death) Last	c. Due to (or as a conse
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prec

Physician/Medical 1 Yes 2 9 Unknown Completed by

CORONARY ARTERY DISEASE CELLULITIS

determined

Hospital

4a. Was an autopsy performed? ☐ Yes 2 ☒ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medica examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending

Accident

Suicide

4 Homicide

29a. Certifier

28a. Date of injury (Month, Day, Year) Investigation 6 Could not be

1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28b. Time of injury

4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE, MD 21225

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

29c. License number 17753

STRAGET

Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Other:

29d. Date signed (Month, Day, Year) 10/13/2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POTES K.S. DHARMASENA, MID 3721

Au ashis, mos

State Registrar 31. Date filed (Month, Day, Year) OCT 1 8 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33455 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ERNICE Month Year BRODKS 1:40 A M LTUBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANUR PILESVILLE BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 213-16-0718 1 🗆 M 2 🗓 F 92 05/12/1920 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, <u>the Medical Examiner must be notified at</u> permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at enter to enter that the modified at enter that the modified at enter that the modified at enter that the modified at enter that the modified at enter that the modified at enter that the modified at enter the enter the modified at enter the modified at enter the enter the enter the enter the modified at enter the enter the enter the enter the enter the enter the enter the enter the enter the enter the enter the enter the enter the enter the ent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 1 No BALTIMORE MD PIKESVILLE 10e. Street and Number 10g. Citizen of What Country? Funeral 4204 OLD MILFORD MILL ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Specify. WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 SECRETARY DEPARTMENT STORE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 NATHAN SILVERSTEIN FANNIE SCHWARTZMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MORTON SILVERSTEIN/BROTHER 3000 STONE CLIFF DRIVE, #308, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM 10/17/2012 REISTERSTOWN, MD Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair a. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fir -1 Priysic an/ disease or condition resulting in death) END STAGE DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed ause (Disease or mjury signed by the attending physician and defached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Uve Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month 1 Yes 2 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been sired director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 🗌 Yes 2 🗹 No Other: in 24 hours and the Funerel Director: And was and the Funerel Director. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural □ Accident 1 ☐ Yes 2 ☐ No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie M-D. 057722 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEONAND RICHARDSON M.P. GREENE TREE RUAP #300 PILLESVILLE MA 21208 1838 31. Date filed (Month, Day, Year) 32. P gistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Ruby Whitley Burns 7:50 am 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Silver Spring Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under Months Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Days Hours (Month, Day, Year) 09/15/1914 215-38-7048 Washington. Director 98 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Montgomery Silver Spring 1 🗌 Yes 2 💢 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 International Drive, #509 20906 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Completed by Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 💢 No Specify 3 X Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation بواااطلم المالية الما 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Office Manager Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Butler Whitley Puah Catherine Efird ge 1 and 2 should be to Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Theodore Burns,Jr. - Son 3720 Stoney Castle Street, Olney, Maryland 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of h
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State 4 Donation 5 Other (Specify) Ft. Lincoln Crematory 10/22/2012 Brentwood, Maryland 21. Signature of Fundral Survice Licensee Simple Tribute Funeral & Cremation Ctr. M00209 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ In the past 12 months? Pregnant at time of death Month Day Year signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician; The law requires Division of Vital Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 💢 No Other: Assisted ြု 1 Inpatient 2 ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending after death. Director: Af 1 Yes 2 No Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 D0060044 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesse Sadikman, M.D., 302 King Farm Blvd., Suite 130, Rockville, Maryland 20850 31. Date filed (M State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State of Maryland		irtment of H tificate of D			_	201	2	201 5	
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	Physicia Medio		PHILLIP G. BO	ROWSKI				Month	Day 15	Year	- 3	50 P M	
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~ *	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	BALTIM If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	g. Bir	tholace (State or Foreign	\dashv
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21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Nas Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	IT.	as Decedent of His Yes, specify Cubar Yes 2 X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		lace - Ame Black, White lify: [4]			
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Baltimore,	Page nent c ant: If Iry or		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → Re 4 → Donation 5 → Other (Specify)	moval from State Cen	netery, crema	ition (Name of atory or other place slaus C	octo em 27,		20c. Locatio Balti			_{ate} ryland	
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). Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/N	1 Yes 2 No	4 Pregnant at time of dea g Unknown		Other (specify)			V	/lonth	Day	Year	
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eco	has he 2	Completed by	-					24a. Was a autops perfori	sy	b. Were autoprior to c death?	topsy find completio	lings available n of cause of	
T E	sician: The certificate irector, pag		25. Was case referred to medical			26. Plac	ce of Death (Check	1 Yes	2 X No	1 🗌 Yes	2 X N	0	
Ĭ	hysici nis cer I direc	일	examiner? 1 Yes 2 No	pital: 1 ☑ Inpatient 2 ☐ EF	R/Outpatient	Other		· · · · · · · · · · · · · · · · · · ·	ence 6 🗆 Ot	her (Speci	ifv)	_	1
Division of Vital Records,	ling P		27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year)	Bb. Time of injury	28c. Injury a work?	at 2	8d. Describe ho					
SIO	Attenc death ctor: /	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home	farm stree		es 2 No	Of Location /Ct	reat and Miss	.	-1.0	61	4
<u>≥</u>	al or / s after al Dire		4 ☐ Homicide determined	building, etc. (Specify)	5, 141111, 54100	i, lactory, office		8f. Location (St. City or Town		ber or Hura	ai Houte i	wumber,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director, to	Medical	(Check 2 \(\sum \) Medical Examiner:	n: To the best of my knowled On the basis of examination ar ractioner: To the best of my kr	nd/or investia	ation, in my opinion.	 death occurred at t 	he time, date an	d place, and d	lue to the co	ause(s) ar	nd manner stated	1.
	To th Withir To th		29b. Signature and title of certifier	detroller. To the best of my ki	iowiedge, dec	29c. License r			9d. Date sign			ar)	1
			P RITE MD			1043	07		10/12	1201	2		
	60		30. Name and address of person who comp	4	Δ.					_			
	State		UAVID AV-TBEAL. 31. Date filed (MOCT/ 128 2012	3 Registrar's Signature	PAJ	[L. D.	LTIMORE	MD	3120	2			-
	Registra	r	001 1 0 2012	Chave S.	gar	le le		Y					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ LEINAAI Month Year 6:10 1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 8188 GLEN E57 DA ANN UNDE . Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days Director Hours (Month, Day, Year) 1 □ M 2 😿 F 576-36-5073 Oct. 4, 1937 Hawaii Usual Residence of Dece 28a-f shov 10a. State 10b. County 27 is marked other than "naturel", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified et</u> 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🗓 No <u>Maryland</u> Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 21122 8188 Forest Glen Drive U.S.A. 12. Was Decedent Ever in U.S.

Armed Forces?

1 A Yes 2 No 1957If Yes, Give 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, <u>چ</u> 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 Hygiene. other than "naturel", 1 ☐ Yes 2 🗓 No Specify: Completed 3 ☐ Widowed 4 ☐ Divorced 1960 Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) of and 2 should be filed withing the Health and Mental Hygien. I item 27 is marked other the Technician Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kamai John ${\sf Ethel}$ Ahulii 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8188 Forest Glen Drive Pasadena, Maryland 21122 George M. Bentz (Husband) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If its any injury or ot Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville V.A. Cem.: 10/23/2012 Crownsville, Maryland 21. Signature of Funeral Service Licensee MOO-732 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SREAST ANCER tuith disease or condition METASTASIN Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Dun to (or as a consequence of attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALEyes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 1 No 4 Pregnant 9 Unknown Pregnant at time of death Day Year To the Hospital or Attending Physician: The law requires unas and within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 N 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No ၉ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sigratur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dur

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 33459 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William F. Cudnik, Jr. 2012 3:14 P. M Öctober Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Joseph Richey Hospice Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) Funeral 8 Date of Birth (Month, Day, Year) Director 215 24 0402 1 **№** M 2 🗆 F 82 Maryland 01/01/1930 Usual Residence of Decede item 27 is merked other then "natural", or items 23a or 28a-f show other traumetic event, the Medical Evantius minst be neathed at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 v Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2005 Casadel Avenue 21230 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ō \$ 1 Never Married 2X Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheetmetal Mechanic 8th Astro Sheet Metal nd Mental Hygier merked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health end Mental tant: If item 27 is merked William F. Cudnik, Sr. Sophia Bogdan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Cudnik / Wife 2005 Casadel Avenue Baltimore, Maryland 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 10/17/2012 Sykesville, Maryland 4 Donation 5 Other (Specify) Lakeview Cemeterv 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 mani 23a. In 1. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwe shock, or heart failure. List only one cause on Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examir siclen end burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): ending physiclen r use as the burial Physician/Medical yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy etter for u in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? 2 🗆 No 1 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ð 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Natural 5 Pending Division To the Hospital or Attendin, within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner State Registrar

(g

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year JOSEBELL CLARK COX OCTOBER 2017 0830 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** RANDALLSTOWN BALTIMORE NORTHWEST If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Min Director 578-46-1996 Usual Residence of Decedent 10 33 VΑ filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rat", or items 23a or 28a-f show Examinar , ust be notified at Director 1 ☐ Yes 2 No MD Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10204 Marriottsville Road 21133 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: er than "natural", o 2 Specify: 3 ₩ Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene.
Important: If item 27 is marked other than Injury or other than the state of the ADM Harte Hankes Elementary/Secondary (0-12) College (1-4or 5+) 10th grade na Supervisor Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roosevelt Ward ပ Addie M. Slayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brenda Suggs-Daughter 10204 Marriottsville Road, Randallstown, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 10/20/12 Woodlawn, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Par/I Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shipt, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease condition resulting in death) **Physician** neumania /Medical Due fo (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examiner Due to (or as a consequence of): Physiclan: The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the SE attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? Yes 2 \(\sqrt{No}\) certificate 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director: 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 14 D 0059736 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOJPITAL 5401 LOURT 31. Date filed (Month, Day, Year) State 18 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G933, 1175, 2012, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Vera Year Stephens Cook Medical 10 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital
5. Social Security Number Baltimore er 1 Year | If Under 24 I 6 Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours Min. (Month, Day, Year) Director 213-34-6230 1 🗆 M 2 🖾 F 79 Yrs. 03 01 33 Georgia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tent of Health and Mental Hygiene.

Tent: If item 27 is marked other then "netural", or items 23e or 28e-f show tant: If item 27 is marked other then "netural", or items 23e or 28e-f show jury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD NA Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3909 Fordleigh Road Apt C 21215 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married Black, White, etc. ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black 3 Divorced Completed Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Oth grade na Aide <u>Masonic Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Robert Stephens Mamie Wilbon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Theodore Cook-Husband 3909 Fordleigh R<u>oad Apt C, Baltimore,</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any Injury or ott 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11/2/2012 Donation 5 Other (Specify) Garrison Forest 10/23/12 Owings Mills, Md 21. Si wat re of Funeral Service Licensee 22 Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that cedesed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Retween Onset and Death Physician disease or condition Medical resulting in death) as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months Month Dav Year 2 NO 1 Yes 2 Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 No 1 Yes director, 25. Was case referred to media Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျှ Other: 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral o 27. Manner of Beath Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident neral Director: A filled in by the f Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined hin 24 hours a the Funeral C Hospital Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 Certifying Nurse 29b. Signature and title of 29c. Licerse numbe 30. Name and cause of death (Item 23a) (Ty Suite State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Essex 215 Magnolia Terrace 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Days Months Hours Min 01171 001/11939 PA 205-28-7076 73 Director 1 X M 2 □ F Yrs Usual Residence of Decedent 10b County 10c. City. Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director Baltimore Essex MD 1 🗌 Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 21221 10g. Citizen of What Country? Funeral 215 Magnolia Terrace USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give Black White etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 Widowed 4 Divorced Completed Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Owner/Operator Photo Photography Mental Hygiene. Be 18. Mother's Name (First, Middle, Maiden Surname)
Clotilda De Leo 17. Father's Name (First, Middle, Last) John Conti permit. Page 1 end 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code)
215 Magnolia Terrace Essex MD 21221 19a. Informant's Name/Relationship (Type, Print) Melinda Diane Conti Wife 20b. Place of Disposition (Name of cermetery, crematory or other partial antic Crem 20c. Location - City or Town, State 20a Method of Disposition Date 1 Burial 2X Cremation 3 Removal from State Glen Burnie MD 10/16/12 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Crem & Fun Serv 21. Signature of Funeral Service Licensee ThomasAllenPA 7090 Ridge Rd Hanover MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit The lew requires that the death certificate be executed Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the a ld be detached f 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has 1 🗌 Yes certificate 2 🗌 No Yes 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 12 No 1 Inpatient 2 ER/Outpatient 3 DOA 잍 this funeral 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funer 1 Unatural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie na and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, 32. Registra State 1 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #518 Per FH G932 10/18/2012 IIII and Mental Hygiene
state of Maryland Department of Health and Mental Hygiene
amend #8, per fh, g932 10-24-12 sm
Certificate of Death

Reg. No. 2 1 2 State
Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 0600A neodore 10 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Hospital Randallstown 5. Social Security Number 3 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months Davs Hours (Month, Day, Xear) Country) S.C. 72 Director 212-46-4 X M 2 F Yrs Sept, 27, 1940 Usual Residence of Deceden show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours efter death with the Maryland 27 is marked other then "neturel", or items 23e or 28e-f sho treumetic event, the Madical Examirer must be notified at Director y ☐ Yes 2 ☐ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 USA 2503 Frank Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White, etc. 1. Yes 2 No Army If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation Give kind of work done during most of working
Mile DO NOT use retired)
Maintenance Correctional
Officer (Specify only highest grade completed) MD Correctional College (1-4 or 5+) Elementary/Secondary (0-12) Page 1 end 2 should be filed within ment of Health end Mental Hygiene. ent: If item 27 is marked other the ury or other treumetic event, the any or other treumetic event, the any or other treumetic event, the answer or other treumetic event, the answer or other treumetic event, the answer or other treumetic event, the answer or other treumetic event, the answer or other treumetic event. INst / Jessup Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother Representation Maiden Sumame) ဂ္ Debecca Santiago Theodore Colclough, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3303 <u>Dunlin Drive, Balto,Md. 21222</u> Taavon Colclough (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 e Depertment of H Importent: If ite eny injury or oti 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct.25,2012 OwingsMills,Md Garrison Forest 21. Signature of Funeral Service Licenses Calvin B. Scruggs Funeral Home E Preston St. Balto, Md Approximate Interval Between Onset and Death In or the Disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RESPIRATOR Immediate Cause (Final disease or condition resulting in death) FAILURE Physician/ Medical Due to (or as a consequence of): Examiner UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for us a consequence of, attending physician end for use as the burial-transit Hospitel or Attending Physicien: The lew requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day erei Director: After this certificate has been signed by the sfilled in by the funeral director, page 2 should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide work? 1 ☐ Yes 2 ☐ No 5 Pending death. Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (MUS 7126 10 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin, Md 21811 Uzo Unegbu 9715 Healthway Dr. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar <u>nct 1 8 201</u>

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Choinski 3:42P M October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Co. 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 218-42-3018 Director 1 ፟M 2 □ F 71 Yrs. 3-14-1941 Poland permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 300 Gusryan Street 21224 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A Sheet Metal Worker Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wladek Choinski Stella Kowalski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Irene Choinski/Wife 300 Gusryan Street Baltimore, MD 21224 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-19-2012 Holy Rosary Cem. Dundalk, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, PA m00933 1201 Dundalk Avenue Baltimore, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYOCARDI Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): *Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Drivi to for as a consequence of ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Dav Pregnant at time of death Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🙀 No Other: ၉ 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Natural
Accident
Suici Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗀 No within 24 hours after death

To the Funeral Director: completely filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29d. Date signed (Month. Day, Year) 012 of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 7:10 am Kulwant S. Cheema Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore n/a 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours 220-67-2838 Director 62 1 X M 2 □ F May 2, 1950 India 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Madheil Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 4 Pearlwood Court USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 🕅 No If Yes, Give Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: Specify: Asian Indian 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 4 Self Employed Businessman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jai S. Cheema Mohinder K. Riar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranjit S. Cheema/son Pearlwood Court Parkville, Maryland 21234 timore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/20/2012 | Baltimore, Maryland 22. Name and Address of Facility MacNabb Funeral Home, P.A. 21. Signetur of Funeral Service Licensee Stephanie Custer Bai 301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Kalem disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran burial-trar that initiated events Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown this certificate has been signal director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month. Day, Year) DO072551 ho completed cause of death (Item 23a) (Type, Print)

PLAN, LAUCA Sandes, M. MH 5601 Loch Kaven Blvd Bultmon, no 21739

DHMH 17 Rev 06-2011

State Registrar 12-07659 Jorge Cenizal Physic Medical Exar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

CHIZAI		1- For State	State of Maryland	-	cate of Dea		iai i iygierie	Dec 11: 2	012 334
Physici		1. Decedent's Name (First, M	iddle,Last)			<u> </u>	2. Date of D		3. Time of Death
al Exami	iner	Jorge (f	Cenizal		T45.03	T		9, 2012	2250 nrs
		4a. Facility Name (if not institution University Hospital		r)		Town, or Location of imore	of Death	4c. County of	N/A
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last bi				Birth(MM/DD/YYYY	9. Birthplace (State or Foreign
Director —		531–76–6035	1 X M 2 F	69	Yrs. Mor	ths Days Hours	Min. 02/06	/1943	CountryPhilippine
any		Usual Residence of Decedent 10a. State 10b. Cour	·	10c. City, Town	n or Location	_			10d. Inside City Limits
E	_	Manual and American A							
and 2 shown to first within 2 hours arter team with the wazyanu and 2 shown Mental Hygiene. tem 27 is marked Hygiene. tram 27 is marked after than "natural", nr items 23a nr 28a-f she traumatic event, the Medical Examiner must be notified at once	Director	10e. Street and Number		10g. Citizen of Wh	nat Country?				
23a nr 28a-f show notified at once.		7400 Osprey Landi			3	21060		Philippi	nes
nr items ?	Funeral	11. Marital Status 1 Never Married 2	Married 12. Was Deceder Armed Forces	?		dent of Hispanic Orig cify Cuban, Mexican,	in? (Specity Yes or Puerto Rican, etc.)	No- 14. Race White	- American Indian, Black, e, etc.
r, pr	y Fu	3 Widowed 4 X	Divorced If Yes, Give Year	2 X No	1 Yes	2 No specify:		Specify:	Pacific Islander
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ygiene ither t	Som	17. Father's Name (First, Mid-			- CONTEROS		s Name (First, Middle	1 *	
ntal H irked r 'ent, il	Be (Cenizal			Genove	. —	Bartolome	
and Me	To	19a. Informant's Name/Relation	1 (31)				ber or Rural Route N		
fealth and Mental Hygiene. item 27 is marked nther than "natural", traumatic event, the Medical Examiner		Christa E. Neuman 20a. Method of Disposition	`	20b. Place	of Disposition (N	ame of cemetery,	ive Glen Bur Date		City or Town, State
Department of Health and Mental Hygi Important: If item 27 is marked nth injury or other traumatic event, the		1 Burial 2 X Crema		tate	tory or other plac		10/12/2012	Clan Burn	ria Manyland
partme portar ury or		4 Donation 5 Other 21. Signature of Funeral Serv				d Address of Facility			<u>ie, Maryland</u>
		117	Collin				uneral Home Pasadena, M		
sician edical		23a. Part I. Enter the disease failure. List only one cau	use on each line.			e of dying, such as ca	ardiac or respiratory a	arrest, shock, or hea	Approximate Intervalent Between Onset and Death
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iding p	cian/I	23b. Was decedent pregnant i past 12 months?	I Live Dittil	44:6 -444-	2 Fetal deal		pregnancy	Month	Day Year
the atter ed for u	Physic	1 Yes 2 No 9		it time of death	5 Other (S	ecify)			
d by the		Part II. Other significant con	ditions contributing to dea	th but not resultir	ng in the underlyi	ng cause given in Par			bute to the cause of death?
has been signed be 2 should be detac	ed by	End Stage Renal D	Disease						Probably 4 Unknown
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is certi lirector	Be (25. Was case referred to med examiner?	Hospital:	ent 2 ER/C	Outpatient 3	26.Place of Death (Check only one) Nursing Home 5	Residence 6	Other:
After this certificate funeral director, page	ı: To	1 Yes 2 No 27. Manner of Death	28a. Date of In (Month, Day,		Time of Injury	28c. Injury at Work		e how injury occurre	
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within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Medical		Physician: To the best of r Examiner: On the basis of exa and manner stated	amination and/or					
≱ ∺ 8	Me	29b. Signature and title of cer			2	9c. License number		29d. Date signe	ed (Month, Day, Year)
		Carol	Hella	U		O.C.M.E.		October 10	, 2012
, ,			11000						
61		30. Name and address of personal H. Allan, MD	son who completed cause of Assistant Medical E			ore Street Balti	more MD 2122	3	

ORIGINAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#25,27-28f,pen/E,G932,10/18/2012,WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 33467 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 17 Edward James Dorsey Jr. 0220 M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltmore Hospital Agnes 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Days Hours Country) 213-30-6143 Director 1X M 2 □ F 79 11 07 32 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1233 Kevin Road 21229 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Examiner 14. Race - American Indian, Armed Force Black, White, etc. or i þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 item 27 is marked other than "natural", other traumatic event, the Medical Exal 1 Yes 2 No Specify 3√ Widowed 4 Divorced Specify: Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade 2yrs Master Control Director MD Public Television Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ Pattie O. Wynn James E. Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i Marvin Brett Dorsey-Son 1233 Kevin Road, Baltimore, Md 21229 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of I mportant; If ite any injury or of cemetery, crematory or other placel 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9/21/2012 Arbutus, Arbutus Memorial ignature of Funeral Service Licensee Marchand Admiss of Feith 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between 3 Clay anoxic Physician/ encephalopath disease or condition Medical resulting in death) Due to (or as a consequence of): 3 days Examiner intra coamal Se wentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burial-Physician/Medical death certificate be Ses, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ali sean Records, custery Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of has autopsy page performed? Yes 2 No death? or Attending Physician: The certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ျှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury

Pnd Month, Day, Year)

28b. Time of Injury 27. Manner of Death 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completely filled in by the funer **→ N**atural 5 Pending Sept. 14, 2012 1:00 P 1 Yes 2 X No 2 X Accident Investigation Subject fell 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1233 Keyin Road Baltimore, Maryland determined Home Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number P 2-6618 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Abhizket Kumov, M.D. 117/2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD - 21229 Athi jest Kumen 900 S Certan Are 31. Date filed (Month, Bay, Year) State Registrar

w

12 State

Baltimore, Maryland 21215-0036

2,09289

Box

P.O.

Records,

of Vital

Division

30. Name and address of percent who completed cause of death (Item 23a) (Type, Print) William Jan MD 1645 L154 31. Date filed (Month, Day, Year, Registrar

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary P. Delawder October 14 2012 9:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Catonsville Manor Care Woodbridge Valley If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 088-28-9497 Director 1 M 2 X F 75 15, 1937 New York Usual Residence of Decedent fshow ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location Director Maryland Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21228 101 North Beechwood Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Kathleen Murphy William Mamber injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 13 Shady Hill Court, Catonsville, Maryland 21228 Mary Delawder / Daughter-In-Law 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, Garrison Forest 10/25/12 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MacNabb Funeral Home, P.A. Signature of Funeral Service Licensee Thomas Gregor 301 Frederick Road, Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final Physician/ HYPERTENSIVE CARPIONASCULAR disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by DEMENTIA Records, 1 Yes 2 No 3 Probably 4 Unknown completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? MELLITUS 24a. Was an 1 Yes 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of Medical Certificate; 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; Af 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 1 🗸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRINGS VICTORY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death
October 160ay 2012ear 3. Time of Death 10:41A. Physician/ Geneva L. Doherty Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) 8. Date of Birth Months Days Hours Min (Month, Day, Year) 443-14-0882 Director 1 □ M 2 🖾 F Yrs July 16, 1922 Arkansas Item 27 is marked other then "netural", or items 23a or 28e-f sho other traumetic event, the Medical Examiner must be notified at 10h County 10c. City, Town or Location deeth with the Merylend 10d. Inside City Limits Director Maryland | Montgomery Rockville 1 M Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Chancelet Court 20852 United States of America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. à 1 Never Married 2 Married be flied within 72 hours efter Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Nidowed 4 ☐ Divorced Completed Specify: White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mentei Hygiene. marked other then Elementary/Secondary (0-12) College (1-4 or 5+) Travel Professional U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Otis Ficklin Willie Mae Chapman .. Pege 1 end 2 shouid b tment of Heeith end Me tant: If Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Doherty / Son 1674-C Beekman Pl, NW, Washington, D.C. 20009 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date Unk. 20c. Location - City or Town, State Depertment of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arlington, Virginia Arlington National Cemetery 21. Signature of Funeral Service Lice Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850-2805 M00896 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine (holestero or Attending Physician: The lew requires that the deeth certificate be executed Hah ears ettending physicien end for use es the buriei-tren that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Day signed by the et id be deteched for 9 Unknown 9 Unknown art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown peen Cance colon 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pege 2 s autopsy performed? After this certificete funerel director, peg 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No I Director: A Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, within 24 hours efter To the Funerel Direc completely filled in by Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville 9901 MD 20850 Nicole MD Medica 31. Date filed (Month, Day, Year) State OCT Registrar

100/

2/05/21/01

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carol Ann DeMizio October 2012 11:10PM Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner 4b. City, Town, or Location of Death Gilchrist Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 139-36-1202 Director 1 🗆 M 2 🗶 F 67 1945 Feb. 14, New Jersey permit. Pege 1 end 2 should be filed within 72 hours after death with the Manyland Department of Health end Mentel Hyglene importent: If Item 27 is marked other then "neturel", or Iteme 23a or 28e-f show empiripary or other treumetic event, the Modical Exerciting must be notified at once. 10a. State 10c. City, Town or Location Director MD. Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Wineleaf Court 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Arrned Forces? 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 X Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Education Teacher æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) S. Ziobro Stephana Kubas Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina DeMizio/ Daughter 4 Wineleaf Court Cockeysville, MD. 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Mem. Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donation 5 🗀 Other (Specify) 10-20-12 Timonium, MD. 21. Signature of Fu eral Swice Lic 22. Name and Address of Eacility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mith Medical Due to (or as a con equence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ed by the attending physicien end detached for use es the burlei-transit or Attending Physician: The lew requires that the death certificete be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) Month Pregnant at time of death 9 Unknown s been signed by t ? should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitel or Attending Phyeician: The lew within 24 hours after death.

To the Funerei Director: After this certificate has completely filled in by the funeral director, page 2: autopsy performed? Yes 2 2 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 | Nursing Home 5 | Residence 6 [5] Other (Specify) No 3 public 2 🔀 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 🔲 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 58303 OCTOSES 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles ST M UN NOCHOL 6701 31. Date filed (Month State 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LDER 14357 M DCTOBER 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Director 1 M 2 D F "naturai", or items 23a or 28a-f show edical Examiner must be notified at Page 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ent: If item 27 is marked other than "naturai", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? Funeral 4.5. A 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Black White etc. Completed by 1 Yes 1 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Sy. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 4 Donation 5 Other (Specify) 21. Signature Funeral Service Lies 23a. Part. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate cause (Final disease or condition). Onset and Death

NKNOWN Physician/ SEPS1S disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA-RIGHT LOWER LOBE UNKNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine RIGHT LUNG COLLAPSE tate has been signed by the attending physician end page 2 should be detached for use es the burial-transit Cause (Disease or injury DAY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ESRD, CORONARY ARTERY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES, HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 40 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work≀ 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 24433 MD Sindlyga OCTUBER 14,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 SINDHUJA MARUPUDI 900 CATON AVE, BALTIMORE 31. Date filed (Month, Day, Year) State OCT 18 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10b per fh g932 10-18-12 vt so State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10.05 AM Edgerton 06 elen 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N FC Under 24 Hrs. Birthplace (State or Foreign Covinginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 183-169278 Director 90 Clicinn 16 1919 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show N/A ed other than "natural", or items 23a or 28a-f show event, the Modical Experience must be notified at 1 Yes 2 No Director America MB Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2 ☑No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DM59 11C 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be D6512 ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WTAIA PANSITER Worson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Comotory 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY P. MARCH FUNERO/ MOME Pair 1 In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final **Physician** FAILURE TO THRIVE FEW DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FELL YRS EMENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): Box 68760, requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year ∑ O.G. 5 Other (specify) 9 Unknown GEATC Records, F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy After this certificate 2 No Vital 1 ☐ Yes the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 □Yes 2 No after death 2 Accident 3 🗌 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10062634 MD OCT 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MATEEN AWAN 16796 HICKORY RIDGE SO COLUMBIA MD 21044

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ecedent's Name (First_Middle_Last) 2. Date of Death Physician/ Ochober Year orenda 0920 AM ron 12 2012 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Hopking Itosp, ta 15 CIT m-12 If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Davs Hours Min (Month, Day, Year, **Director** 212-44-5550 66 1 M 2X F 26 04 46 NC Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location Director 10d, Inside City Limits notified 28a-f 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? be 23a Funeral 5514 Frederick Ave must 21229 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No
If Yes, Give 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural!" or 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Black Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade na Unemployed Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hugh Ebron Martha Copeland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21223 Carolyn Bass-Sister 1700 Edmondson Ave, Apt 305, Baltimore, 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Coast) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) Mt. Zion 10/19/2012 Baltimore, Md Signatu of Funeral Service License March F/H West Wabash Ave, Baltimore, Md 4300 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fi Physician/ Cardiac arrest Medical resulting in death) Due to (or as a consequence of): Examiner Metastochic Ovanian Sequentially list conditions Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) I ast Physician/Medical Examiner pue to for as a consequence of and Due to (or as a consequence of): resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

State Registrar only one

29b. Signature/and title of certifier

TRANG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VU

1 8 2012

Day, Year

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Or leans

29c. License number

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Balti mere.

29d. Date signed (Month, Day, Year)

October 13, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (O SOHDRA Physician/ EDMONDROH Day 11 Year 12 0200 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death UHIVELLY OF MORNICOND MEDICAL CONTEN BOLTIMOYE croy 5. Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth g. Birthplace (State or Foreign Hours (Month, Day, Year) **Director** 213-64-5461 1 □ M 2 🏋 F 58 09/09/1954 MD Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits must be notified NA 1 X Yes 2 No BALTIMORE 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3118 SEQUOIA AVENUE 21215 USA items death . 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ō 1 Never Married 2 X Married 9 Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 4 YRS <u>Senior Agent</u> State of Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ULYSSES THOMPSON ERMA MATTHEWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL EDMONDSON-HUSBAND 3118 SEQUOIA AVE. BALTO., MD t: If item ? Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 10/23/12 Owings Mills, Signature of Funeral Service Licensee March Address of Facility t 4300 Wabash Ave, Baltimore, Md 21215 23a. Parl 1. Enter the Asease, or complications that caused shock, or hear failure. List only one cause on each line. Immediate Cause (Final sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 2Eb172 Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** BUD STAGE CAP-DIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami PONE KNOWEN ILVOURY burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy yes 2 No 1 Yes 2 No B 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Minpatient 2 ER/Outpatient 3 DOA မ this s after death. I Director: After the Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Matural Natural 5 Pending injury Accident Investigation filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 24 hours Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State Registrar and, april

31. Date filed (Month, Pay, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

done

RIGAGIA

22 SOUTH GREENE STREET BACTIMORE, MARY COND 21201

19/11/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 14^{Day} 2012 Clara Fisher 2:45 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 214-24-7965 Days Hours Min. Director 1 M 2 K F 84 July 26, 1928 Usual Residence of Decedent i Hygiene. I other then "neturel", or items 23a or 28a-f shov vent, the Madical Examirer must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Baltimore Catonsville 1 ☐ Yes 2X No MD 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Funeral 21228 USA 309 Waveland Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. White ğ 1 Never Married 2 Married 21215-0036 a.m. 1 ☐ Yes 2 No Specify. Specify 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired). Bell Telephone Elementary/Secondary (0-12) College (1-4 or 5+) Office e 1 end 2 should be filed wit of Health end Mentel Hygie If item 27 is merked other or other traumatic event, ID Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard D. Love Virginia Sponsler 14, 2012 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Waveland Road; Catonsville, MD 21228 permit. Page 1 end 2 sh Department of Health er Importent: If Item 27 is eny injury or other trau Therese Alagna Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) OCTOBER Garrison Forest VA Cem 10/25/2012 Owings Mills, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licensee Mo1234 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition CEREBROVASCULAR ACCIDENT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): The lew requires that the deeth certificate be executed ed by the attending physician end detached for use es the burial-translt that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? CLARA FISHER Day Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cate has been signe r, page 2 should be c Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 1 Yes 2 No the Hospitei or Attending Physicien: director, **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) **HOSPICE** 1 🗌 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred X Natural injury 5 Pending hours after death within 24 hours after death

To the Funeral Director: A
completely filled in by the f 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Deftiying Prysician: To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The deftiying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of car 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE L. MORGAN, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
OCT 1 8 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ Dolores Gertrude Fitzgerald 5:28 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Gilchrist Center Howard County Columbia 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 216-28-1876 79 1 🗆 M 2🎾 F Jan. 29, 1933 Maryland 1 end 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene.
I item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Nexticel Evamin in must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2X No **Baltimore** Halethorpe Maryland 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21227 United States 3300 Benson Avenue, Apt. 308 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give
Year or Dates. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Miller Schalitzky Anthony permit. Pege 1 and 2 st.
Depertment of Health en.
Important: If Item 27 is m
any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2003 Oak Lodge Rd., Catonsville, Maryland 21228 Margaret Lanasa / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/18/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc. 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 SOU! 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death OMPLICATIONS SEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the burlel-trensit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗌 Nursing Home 5 🗎 Residence 6 🗖 Other (Specify) é 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 ☐ Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number D72139

State

Registrar

DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6336

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 **Physician** Month Christina C. Fisher October 15. 10:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care at Towson Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ м 2√10 Г Months Hours Min 86 Director 220-18-6125 MD Aug 31. 1926 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the "Mulcal Examinar must be martined once. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Towson 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 East Joppa Road 21286 U.S.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 ∏Yes 2 XX If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐Yes 2XXXNo þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) St. Thomas Aquinas Church Secretary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Vincentzo Campisi Rose Mary Angellatta 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Fisher (Son) 219 Queen Anne Club Drive Stevensville, MD 21666 20a. Method of Disposition

XXX Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Woodlawn Cemetery 10/19/12 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of FacilityBurgee Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Damen **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Sequentially list conditions, it any cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trai resulting in death) Last Due to (or as a consequence of Physician/Medical the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 221No 2)XNo 1 □ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O. this funeral After ours after death.

leral Director: A
filled in by the fu death. within 24 hours a

Baltimore, Maryland 21215-0036

27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10812 BM VIVENUT V9/20 WD. 7505

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year Mabel G. Freitag 2012 15 Oct. 7:58 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 200 Belmont Forest Court Unit 301 Timonium Baltimore 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours **Director** 238-30-8997 1 □ M 2 🗓 F May 6 1920 Usual Residence of Deced chow 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f s MD Baltimore Timonium 1 ☐ Yes 2 🗓 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a 200 Belmont Forest Court Unit 301 21093 USA 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by Black, White, etc. other than "natural", or ent, the Medical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give 3 🗆 Widowed 4 🗆 Divorced white Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ano con Health and the street is a second of Health and the second of th 2 Hiram Weldon Hemric Weldon H. Hemric Minnie L. Chapel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gae C. Bradley/daughter P.O. Box 2428 P.M.B. 22696, Pensacola, FL 32513 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ott once. 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Moreland Memorial Park 10/19/12 4 Donation 5 Other (Specify Balto., MD gna Fynera Service Lice see 21. 2 gn 3 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
Timonium, MD 21093 10 W. Padonia Rd. 23a. Part 1. Enter he isease, or complication that called the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Caus (Fi al disease or condi – resulting in death) Physician/ TILURE 70 THRIVE Medical **Examiner** EMENTIA 5425 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) -tran that initiated events resulting in death) Last and Due to (or as a consequence of) burialthe attending physician hed for use as the buria Physician/Medical Box 68760 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery Month Dav 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, RENM FAILURE, PREIPHERM Records, Be Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown LAGULLAR DISEASE, RENT ARTERY STENDSIS 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an has autopsy performed MYPERLIPIOTOMIA Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum_\) Nursing Home 5 \(\vert\) Residence 6 \(\sum_\) Other (Specify) 1 ☐ Yes 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After Hospital or Attending Natural 5 Pending work?
1 Yes 2 No Accident the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 053095 OCTOBER 16, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Texas Station Ct., Timonium, MD Suite 210 Dr. Eric Carr 31. Date filed (Month, Day, Year) State DCT 18 Registra

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5618 Per FH G932 10/25/2012 JH State of Maryland / Department of Health and Mental Hygiene 33480 State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Physician/ Day Year George W. Forrest, Sr. SA Medical 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death VEN timore N/A **Funeral** 228-14-2559 220-14-2559 6 Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 - F Months Days Hours Min (Month, Day, Year) Director 93 VA. Dec 13, 1918 Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified MD N/A **Baltimore** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1015 Veronica Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? 0 Black, White, etc. þ 1 Never Married 2 Married X Yes 2 No 5/26/1942 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: "natural", If Yes, Give 3 X Widowed 4 Divorced Specify: Black Completed 10/29/194 Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) **Electronics** Self Employed 12 Be 18. Mother's Name (First, Middle, Maiden Syrname) Beatrice F. Smith Bernice E. Smith 17. Father's Name (First, Middle, Last) ပ Moses Forrest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Forrest, Jr. 20 Greenapple Court, Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veterans Cemetery Oct 17, 2012 Crownsville, Md. . Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death 4 cute Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any color cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of, been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 2 🗀 No 1 🗌 Yes Yes Vital 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury Division work 1 Yes 2 🗌 No __ Accident Investigation within 24 hours after deat To the Funeral Director. Suicide
Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie M.D 30. Name and agaress of person who completed cause of death (Item 23a) (Type, Print) 3900 AVEN 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 33481 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Leona Goodman Fribush 2012 12:20a M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, 16) **Funeral** 6. Sex 9. Birthplace (State or Foreign 1 □ M 2 🎗 F Country) Maryland Director 216-16-0987 Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland Silver Spring 1 🗆 Yes 2 🔀 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 14510 Homecrest Road, #2010 20906 u.s.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, ,0 Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Max Goodman Bessie Sosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stuart Fribush - Son 979 Farm Haven Drive, Rockville, Maryland 20852 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State B'nai Israel Cemetery 10/18/2012|Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner UNKNOWN PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death). Let Due to (or as a consequence of, Examir that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 2 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital: 1 L Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D71796 MD 16 MARGEDU ass of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd, 6121 ROCKVILLE 20852 31. Date filed (Month, Day, Year) OCT 1 8 2012 32. Registrar & Signature

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Division of Vital Records, P.O. Box 68760

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Sox 6876 Jeath certificate e attending phy for use as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ecto	topic pregnancy		23d. Date of deliver	y Day Year
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ords, w requires been should	ete			24a, Was an		topsy findings available completion of cause of
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OD C ending ath. rr. Aft	틶	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2			jumped fro f a hotel	m the 5th
Visco Visco	Certification:	2 Accident Investigation Fd 10-13-12 Fd 10:17 pm See. Place of Injury - At home, farm, street, factory, office building,	i. etc. 28f.	Location (Str	eet and Number or Ru	ral Route Number City
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.				
	ž	29b. Signature and title of certifier 29c. License number	ber		29d. Date signed (Mo)	
8	L	O.C.M.E.			October 14, 2012	<u> </u>
olipped		 Name and address of person who completed cause of death (Ilem 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore 	∍, MD 21223	3		
Sta Regist	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DHMH 17 Rev 1/20		OCT 1 8 2012 Consum A. Jackson ORIGINAL		-		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Norma L. Goiri 8:45 Medical October 16 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 9708 Harvester Circle Baltimore Perry Hall Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Days Hours Min Phillipines 212-69-2637 Director 77 April1, 1935 Usual Residence of Deceden 10b. County 10a. State within 72 hours after death with the Maryland r then "naturel", or Items 23a or 28a-f eho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore PerryHall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 9708 Harvester Circle USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 2 1 Never Married 2 Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X☐ No Specify Specify: Filipino Completed 3 ₩ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If Item 27 Is marked other then ' College (1-4 or 5+) Elementary/Secondary (0-12) Pharmacist Own Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jose Locsin Mary Villanueva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Goiri / Daughter 9708 Harvester Circle Perry Hall, Maryland 21128 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of B
Important: If Its
eny injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 10/18/2012 Baltimore, Maryland ce of Funeral Service Licensee Stephanie Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. Signa 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ase or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Examine Due to (or as a consequence of): buriel-trensit Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 After this certificate has been signed by the attending physioneral director, page 2 should be detached for use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Physis within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral directors. မှ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending injury ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number Assoc Protector 51208 3 ss of person who completed cause of death (Item 23a) (Type Print)

State Registrar 32. Registras Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCHOBER 15:52 M Greenhill Linwood Α. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AGNES BALTIMORE HOSPITAL If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month. Day, Year) Country 218-44-2082 Director 14 M 2 D F 45 VA 04 01 Usual Residence of Decedent flied within 72 hours efter deeth with the Merylend tel Hyglena. A other then "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 U.S.A. 34 Walden Naple Ct. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit. Department of Health and Mentel Hygler important: if item 27 is merked other ti any injury or other treumetic event, the once. Harbor Hospital 2th grade <u>ansportation Driver</u> 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Parker Adolphus Greenhill Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 Walden Naple Ct., Baltimore, Md 21207 Karen Greenhill-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 10/20/12Arbutus, Md 22. Name and Address of Facility arch F/H West 4300 Wabash Ave, . Signature of Funeral Service Licenses Thompson Baltimore, 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the Cause (Final disease) or condition resulting in death)

a.

Due to for as a consequence off: Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events s a consequence of Hospitel or Attending Physician: The lew requires that the deeth certificate be executed ettending physicien end I for use es the burial-transit he Due to (or as a consequence of): resulting in death) Last Physician/Medical ivision of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day ed by the ef 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq cete hes been signer, pega 2 should be c Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete 1 ☐ Yes 2 ☐ No Yes 2 diractor, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1⊡Yes 2⊡No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA i Director: After this ad in by the funerel d 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 6 ☐ Could not be 24 hours efter de Funeral Directo letely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ᇡ 29a. Certifie 1 Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Expenser: On the basis of examin the land/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year) 50700 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIL 31. Date filed (Month, Day, Year) 32. A State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James Tivon Holden Jr. 12-07697 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2012 33487 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last 2. Date of Death Month Day October 11, 2012 Medical Examiner JAMES TIVON HOLDEN 0300 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director 019-71-3733 1 M 2 F 09/30/2011 Yrs Country) M Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD BALTIMORE Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importator: If item 27 is marked other than "natural", or items 23a or 28a-f sho
rioury or other traumatic evect, the Medical Examiner must be notified as once. 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? USA 21218 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry NA Completed Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) æ JAMES TERKIRA BAILEY HOLDEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 347 E. 27th St. BALTIMORE, Md. 21218 BAILEY TERKIRA MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD Dulaney VALLEY 10/18/12 4 Donation 5 Other Specify: 21. Signature of Funer I Strvice Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resp **Physician** Approximate Interval failure. List only one cause on each line /Medical tween Onset and a Smoke Inhalation and Thermal Injuries Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Atteodiog Physiciao: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 Fetal death Day Year Pregnant at time of death 5 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 V No 25. Was case referred to medical funeral director, 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 ✔ Yes 28a. Date of Injury (Month_Day,Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Oct 11, 2012 0206 hrs Subject victim of house fire Pending within 24 hours after death.

To the Fuoeral Director: 1 Yes 2 ✔ No filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 5601 Denwood Road, Baltimore, MD Homicide (Specify) Townhouse / Rowhouse 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) anos O.C.M.E. October 11, 2012 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

OCME

12-06024 Carole Lee Hewitt

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2012 33488

		1- For State Registrar	Ce	rtificate of Dea		indi riygiono	Reg. No.	112 3340			
Physici edical Exam		Decedent's Name (First, Middle,Las	t)			2. Date of [Month	Death	3. Time of Death			
~ulcar Exam	mei	Carol Lee Hew 4a. Facility Name (if not institution, give		4h City	, Town, or Locatio		11, 2012 Year 4c. County of	1742 hrs			
		Route 144 at mile marker			le Orleans	II OI Deatti	Allegany	Deatti			
Funeral		Social Security Number 6. S	7. Age (In yrs.	last birthday) If U	nder 1 Year If Un	ider 24Hrs. 8. Date of	f Birth (MM/DD/YYYY)	9. Birthplace (State or			
Director		212-46-0927	9-1944	Country) MD							
' any		10a. State 10b. County	10c, City	, Town or Location			···	10d. Inside City Limits			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene it and: If liten 27 is marked other than "natural", or items 23a or 28a-f abow or other traumatic event, the Medical Examiner must be notified at once.	ᅙ	WVA Morgan	n l	Great Cac				1 Yes 2 No			
e Mary or 28a ied at	irec	10e. Street and Number			Zip Code		10g. Citizen of What	Country?			
s 23a e notif	퍨	139 Copperline 7	[rai] 12. Was Decedent Ever in U		25422	rigin? (Specify Yes or	U.S.A.	American Indian, Black,			
leath v r item	Funeral Director	1 Never Married 2 Married				an, Puerto Rican, etc.)	White, e				
after o	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes	2 No specif	y:	Specify:	hite			
hours 'natur Exam	pe	15. Decedent's Education (Specify on		16a. Decedent's Usu during most of v	al Occupation (Giv vorking life. DO NO		16b. Kind of Busin	ess/Industry			
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121; l be fil ental F urked	Be	Ellis Bunce				Dora Brown					
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and 2 lealth tem 2		Charles Leon Hewit 20a. Method of Disposition	20b.	208 Copp Place of Disposition (N	erline Ti ame of cemetery,	rail Great	Cacapon, V				
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Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	see Sm		nd Address of Facil	ity		ourg, MD			
		John A. Anderson	perDVR	ISt. Be	rkelev S	n Funeral prings, WV	25411				
Physician		23a. Part I, Enter the disease, or compl failure. List only one cause on ear	ch line.	. Do not enter the mod	e of dying, such as	cardiac or respiratory	arrest, shock, or heart	Approximate Interval Between Onset and			
Examiner			Multiple Injuries Due to (or as a consequence o	f)·				Death			
		Sequentially list conditions, b	sas to (or as a consequence o	.,,.							
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d d	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence o	f):							
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760, cate be physici	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	nancy			23d. Date of del	ivery			
Box 687 e death certific the attending of	cian	past 12 months?	1 Live birth 4 Pregnant at time of de	2 Fetal deat	_	ic pregnancy	Month	Day Year			
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ords, w requir	letec					24a. Wa		e autopsy findings available to completion of cause of			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. a) Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed					1 ✓ Ye	rformed? deat				
ital ician: s certificactor	B	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3	26.Place of Death	(Check only one) Nursing Home 5	Residence 6	NIL COLOR			
of Ving Physical After this uneral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury at Wor		e how injury occurred	other: Scene			
ion ttendin leath tor: A the fur	ation	1 Natural 5 Pending 2 Accident Investigatio	Aug 11, 2012	1735 hrs	1 Yes 2 ₩	No Passenge	r on a motorcycle	to auto collision			
Division spital or Attenchours after death neeral Director:	Certification:	3 Suicide 6 Could not b determined	28e Place of Injury - At he		ry, office building, e	or Town		Rural Route Number, City			
Hospi 24 hou Funer rtely fil		29a. Certifier (Check only 1 Certifying Physicia	n: To the best of my knowledge	ge, death occurred at the		lace, and due to the ca	ause(s) and manner as	stated.			
To the Ho within 24 P To the Fu	Medical	one) 2 Medical Examiner:	On the basis of examination a and manner stated.								
	2	29b. Signature and title of certifier	// ->	29	9c. License number O.C.M.E.		29d. Date signed				
	ŀ	30. Name and address of person who co	mpleted cause of death (Non	23a)	O.O.IVI.E.		August 12, 20				
			Assistant Medical Exa		altimore Stree	t, Baltimore, MD	21223				
St	ate	31. Date filed (Month DaysYear)	32. Registra s Signal	Te Kal							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ Howell 35 am Lee Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 802 N. Marlyn Avenue Essex 5. Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours North Carolina **Director** 219-38-6270 1 M 2 T F 88 1924 May 9, 28e-f shov 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Essex 1 Tes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 238 Funeral USA 21221 802 N. Marlyn Avenue Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. ò <u>۾</u> 1 Never Mam'ed 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "neturei", leted Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Comp Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 10 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 end 2 should be file ment of Health end Mental I ent: If item 27 is marked o Ollie Wilcox Martin Wilcox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 N. Marlyn Avenue, Essex, Maryland 21221 Diane Howell Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Importent: If it eny injury or o October 19, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) emetery, crematory or other place Holly Hill Memorial MIddle River, MD. 2012 21. Signature of Funeral Service Lice 22. Name and Address of Facility.
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD MCILTY 23a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. k, or heart failure. List only one cause on each line. Approximate Interval Between iate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami The law requires that the death certificete be executed anding physicien end use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical OM. 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 menths?

1 Yes 2 No Day Year 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 1 ☐ Yes 2 ☐ No or Attending Physicien: Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funerel Director: A 2 Accident
3 Suicide Investigation М 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospitel Medical within 24 hou To the Fune completely fi 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Cousing Gure

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elmer Haas 11:30 PM October 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹M 2 □ F Months Days Director 82 March 26, <u>214-24-3840</u> 1930 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1X Yes 2 ☐ No Director Maryland Baltimore City n/a 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? "natural", or items 23a or 1300 South Elwood Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene, Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) 10 n/a Baker Bread/Bakery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Haas John Esther Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Kundratic/Niece 3306 Forge Hill Road, Street, MD 21154 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10.18.12 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland permit. Bryan W. Clar 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Clary 23a. Part 1. Enter 1 di sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt fai ure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Caus (E) al disease or condition resulting in death) Asplication
Due (or as a consequ Physician FREUMONIA /Medical (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unleaded or highly Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Mnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မ Director: After this d in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1. Natural 5 Pending investigation (Month, Day Year) 1 Tes 2 No 2 Accident hours after death 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

Alexande, Kevin 31. Date filed (Month, Day, Year) OCT 18 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1487953865

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

(check only

29b. Signature and title of certifier

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shirley . 201 Т. Houck 2 October Medical 12:40P M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Care Center Towson Baltimore Social Security Number 7. Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 215-60-6585 1 □ M 2 🖫 F 60 Jan 15,1952WestVirginia 28a-f shov th and Mental Hygiene. ?7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Md. Baltimore City 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 633 South Lehigh Street 21224 U.S.A. Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene. I team 27 Is marked other than "natural", or items ury or other traumatic event, the <u>Medical Examiner mung</u> or other traumatic event, the <u>Medical Examiner mung</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Black, White, etc. ρ 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8th Roofer Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Scott Virginia Shaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 633 South Lehigh Street Baltimore, Md.21224 Johnny M. Scott - Brother 20a. Method of Disposition Department of H Important: If ite any Injury or oth 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory: 19, 2012 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facilit Kaczorowski Funeral Home, PA M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hronic disease or condition resulting in death) obstructive 120RS Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown ed by the at detached fo Day Year Division of Vital Records, P.O. ate has been signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No 욘 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) WS ALC 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) US8303 DCTUBER 15 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charlec amie NOKMET M 6701 31. Date filed (Month 18 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2012 6:00 PM CLAIRE M. HACK Medical. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A HOSPITAL - OF BALTIMORE BALTIMORE Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/23/1930 **Funeral** 9. Birthplace (State or Foreign Days Min 212-30-3173 Country Director 1 M 2 X F 82 MD Usual Residence of Decedent 27 is marked other than "nature!", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6800 SYLVALE COURT 21209 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 14. Race - American Indian Completed by Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify. If Yes, Give WHITE 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည pe WILLIAM LAUMAN MARIE TUCKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 JOEL HACK/HUSBAND 6800 SYLVALE COURT, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Page 1 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) DRUID RIDGE CEMETERY 10/17/2012 PIK<u>ESVILLE, MD</u> 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ ACUTE MYOCARDIAL Medical resulting in death) Due to (or as a consequence of): <Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events by the attending physician and tached for use as the burlal-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav 9 Unknown 9 Unknown s been signed by should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 숩 HYPERLIPIDEMIA CARDIAC Completed 1 Yes 2 No 3 Probably 4 Unknown GOUT DISEASE, 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 autopsy perform 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by after I Dire 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital of within 24 hours at To the Funeral D completely filled it Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) - NACHIKET APTE MBBS RES-000 2012 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NACHIKET APTE MBBS SINAL HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year) State back Registrar <u>nct 18201</u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jones -		State of Maryland / Department of He		2012 334
Physici		Decedent's Name (First, Middle,Last)	2. Dat	e of Death 3. Time of Death
		4a. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Death	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24Hrs. 8. D.	ate of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) M.D.
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or death w	/ Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. 13. Was Decedent Ever in U.S. 14. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S. 16. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 17. Was Decedent Ever in U.S. 18. Was Decedent Ever in U.S. 19. Was Decedent Ever	edent of Hispanic Origin? (Specify Y pecify Cuban, Mexican, Puerto Rican,	
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ges l and of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (crematory or other place)	Name of cemetery, Date	20c. Location - City or Town, State
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Dep Dep		pletra plavis MOISAD 4905	York ROAD. BA	TIMORE, MD 21212
hysician /Medical		failure. List only one cause on each line.	de of dying, such as cardiac or respira	atory arrest, shock, or heart Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wounds (2) of Neck Due to (or as a consequence of):		Death
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executed an and al - transit		events resulting in death) Last Due to (or as a consequence of): dd		
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To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fil	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	he time, date and place, and due to the my opinion, death occurred at the time	ne cause(s) and manner as stated e, date and place, and due to the cause(s)
L > L 2	ž	201 01	9c. License number	29d. Date signed (Month, Day, Year)
Į.	- 1	ひ-'ひし・	O.C.M.E.	October 9, 2012
	-	30. Name and address of person who completed acress of death (New 22-1		
√		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. B 31. Date filed (Month, Day Xear) 32. Registrar's Signature	altimore Street, Baltimore, N	ID 21223

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month. 1: 30 AM Ida A. Juhrs 2012 Medical 4a. Facility Name (if not institution, give street, and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St- Agnes HOSDI tal altimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours 155-01-2746 Director 89 1 ☐ M 2 F 11/3/1922 New Jersey 10a. State 10b. County 10c. City, Town or Location Director Catonsville Baltimore MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 1502 Frederick Road USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2X Married 1 Yes 2 No If Yes, Give 1 ☐ Yes 2X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) United States Navy Elementary/Secondary (0-12) 1 2 College (1-4 or 5+) WAVE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lester H. Hutchinson Lena Krieg 19a Informant's Name/Relationship (Type Print) Kristin Noppenberger granddaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2220 Rock Haven Ave Catonsville MD 228 20b. Place of Disposition (Name of Absertion Cemetery Commission Country Disposition (Name of Absertion Prest Officery 10/20/12 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Absecon NJ: 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHarman Funeral Service 7221 Grayburn Dr Glen Burnie MD 21061 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Castrointestinal Henorrha Physician/ Tue to (or as a consequence of): disease or condition Medical resulting in death) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ettending physiclan end I for use es the burial-transIt Hospital or Attending Physicien: The law requires thet the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 No by the g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificete Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐼 No ၉ 1 Inpatient 2 ER/Outpatient 3 II DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No death. Investigation Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after or To the Funerel Direct completely filled in by Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) \$ 46505 evenno Mes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Twanmoh MD 700 Caton 31. Date filed (Month, Day, Year) State 8

DHMH 17 Rev 06-2011

Registrar

State

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 32 Registrar's Fignature

Ana Rubio M.D., Ph. D.

OCME

T 8 2012

ORIGINAL

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

October 16, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of M	laryland	I / Depa	artmen <i>rtificat</i>	t of Hea <i>e of De</i>	ilth and eath	Mental Hy	giene Reg. No.		33498					
	Physic /Medi										15 2012	3. Time of Death 10:00 A M						
	Examile Funeral Director	ner		nter	BAltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of				8. Date of Bi	4c. County of D N/A f Birth (Day Year) 9. 1,2 1922 MN		. Birthplace (State or Foreign						
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County N/			Town or Lo	ocation	Baltimo	ore				10d. Inside City Limits					
	th with the 23a or 28a	Funeral Director	10e. Street and Number 2211 West Rogers Aven	ue			10f. Zip	Code 21209)			zen of What Cou						
036	ours after des al', or Itema Examiner m	by	11. Marital Status 1 Never Married 2XX Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	?	1	Was Deced f Yes, spec 1 ☐ Yes		nic Origin? (S exican, Puer pecify:	pecify Yes or No to Rican, etc.)	1	14. Race - Americ Black, White, Specify: Whi	etc.					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or itema 23a or 28a-f show styl hjury or other traumatic event, the Medical Examiner must be notified at ance.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or		16a. Deced (Give life. L	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			rking	16b. Kind of Busine		,					
yland 2	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last, Berger)				18.	_	ne (First, Middle) e Hannah	, Maiden	Own Ho	ile					
Baltimore, Mary	s 1 and 2 shi Health and tem 27 tem other traum	Ì	19a. Informant's Name/Relationship (Bruse Jones (Son) 20a. Method of Disposition		20b. Plac	4902 V	Vilmslo	w Road)	r Town, State, Zip						
	permit. Pages Department of Important: If I eny Injury or once.		1 ☐ Burial 2 XX Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifications of Funeral Service Liver 1)	y)		ntic Cr 22	emator	y	10/1 Facility But	7/12	G1en	Burnie, M						
Physicia /Medic Examin	be attending physicien and lor use as the burial-transit of or use as the burial-transit	Completed by Physician/Medical Examiner		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	one cause on each i	a consequent	Do not enter Dollar noe of):		of dying, such					Approximate Interval Between Onset and Death				
C. Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 mgaths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3 🗌	Ectopic pre Other (spe				2	3d. Date of delive Month	ry Day Year					
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-	blas has					25. Was case referred to medical							1□ Yes	med? 2 No	24b. Were autop prior to con death? 1 Yes	osy findings available npletion of cause of 2 \(\text{No} \)		
5	hysich this cer al direct	To B	examiner? 1 Yes. 2 No	Hospital: 1 ☐ Inpatie		VOutpatient	3 DOA	04		th <i>(Check only o</i> ome 5 ☐ Resid		Other (Specify	·					
ouo	th. : After s funera	tion:	27. Many fer of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui	Year) 28	Bb. Time of Injury	28 M	c. Injury at Work? 1 T Yes	2 🗆 No	28d. Describe h	ow injury	occurred						
DIVISION	To the Hospital or Attending Physicien: The within 24 hours alter death. To the Funeral Director. After this certificate completely filled in by the funeral director, pag	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju	Be. Place of Injury - At home, farm, street, factory, office 28f. Location					28f. Location (S City or Tow	cation (Street and Number or Rural Route Number, y or Town, State)							
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	on T will		29b. Signature and the py certified) MD				DO06	4788		Oct	signed (Month, I	6 2012					
	DV			ompleted cause of de	821 N	a) (Type, P	rint) AW 1	T, SO	ITE 3	60 1, BA	CTIM	IORE MD	21201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 16 Floyd 4:00 A S. Jackson Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Middle River Perch Court 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Hours 217-20-0869 Director 1 X M 2 U F 86 Oct. 31, 1925 West Virginia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Marvland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Perch Court 21220 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No 1943 If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced -1946Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Continental Oil Elementary/Secondary (0-12) College (1-4 or 5+) Training Director Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Stacy Lowman Jackson Minnie May Aberegg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Deutsch / Daughter Perch Court, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. | 10/17/2012 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland Inc 21. Signature of Funeral Service Licensee Alyson K Taylor 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ta disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hurial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 4360 10-17-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fran 2200 0 31. Date filed (Month, Day, Year OCT 1 8 2012 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registra 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ M. Christabel Johnston Month Oct 15, 2012 6:18 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Encore Lorien of Ellicott City Ellicott City** Howard 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** 9. Birthplace (State or Foreign 579-05-2807 Days 93 Hours (Month, Day, Year) Dec 25, 1918 Director 1 🗆 M 2 💢 F Usual Residence of Deceden 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified MD Howard **Ellicott City** 1 Yes 2 X No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4909 Evening Sky Ct. 21043 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. 0 þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White "natural", Completed Year or Dates r than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Hygiene. the Sales Associate Retail other 27 is marked other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ပ **Magruder Dent Coe** Annie Florencce Brady 19a. Informant's Name/Relationship (Type, Print) et and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Miller Daughter 4909 Evening Sky Ct. Ellicott City, MD 21043 Health item 27 other tra 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o ō 1 Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery Oct 19, 2012 Silver Spring, MD 4 Donation 5 Other (Specify) atore of Fune 11 erv e Licen 22. Name and Address of Facilities. P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ATHEROSCLEROTIC HEART DISEANE 12005 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to his reclassic cause. Enter Underlying Physician/Medical Examiner Due to for sela controllience on burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year 5 Other (specify) Day 1 Yes 2 2 X No 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hyper seusion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate Yes 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) s after death. filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defitying Nystem 19 the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29c. License number 29d. Date signed (Month, Day, Year) Spepte MD 00053150 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MP Len hayo Ra

Shakunmale

31. Date filed (Month, Day, Year)

State Registrar DHMH 17 Rev 06-2011

ORIGINAL

21045

gupte 9650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ octobes 8:00 PM Isabelle Irene Keenan 206 Medical 4a. Facility Name (if not institution, give street and number) Examiner County of Death guare osedale moi **Funeral** Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Hours Min. Director 216 -14-1485 1 □ M 2 🗓 F 92 Yrs 08-11-1920 Maryland Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Maryland Middle River 1 Yes 2x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 307 Tidewater Lane 21220 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 No 1 Yes 2 X No Specify: White 3 N Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Clerk Baltimore Sun Paper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bernard Cox Katherine Phillips 19a. Informant's Name/Relationship (Type, Print) echan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Kip Keenan - Step Son 8922 Parlo Road Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Most Holy Redeemer 10-20-2012 Baltimore, MD 21. Signature A Funeral Service Licenses 22. Name and Address of Facility 5305 Harford Road Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the clsease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Shysician. disease or condition resulting in death) Medical Due to (or as a con-Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated secret.) Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Inneat director, page 2 should be deteched for use es the burla-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes Certificate: To 2 ₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Matural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation
 3 Certifying Nurse Practitioner: To the best of my knowledge death occurred at the time, data and plane, and due to the cauce(e) and marrier constated 29b. Signature and title of certifie 29c. License number 73722 of Willian 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN Square DR 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0ctober 4:20 pm George John Koroulakis Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Rockville Montgomery Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 578-52-7236 1 X M 2 □ F 11/21/1925 Greece 86 nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland sartment of Health and Mental Hygiene. nortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🛱 No Montgomery Rockville Maryland 10e. Street and Numbe 10g. Citizen of What Country? Funeral U.S.A. 20852 5809 Nicholson Lane,#608 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Narried þ 1 ☐ Yes 2 💢 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Ulidowed 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only high t grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Restaurant Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Eirini Liapis Ioannis Koroulakis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5809 Nicholson Lane,#608,Rockville, Maryland 20852 Renate Koroulakis - Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State Ft. Lincoln Crematory: 10/18/2012 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signalure of Funeral Service Licenses MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 0 Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed Dysphagia Due to (or as a consequence of): 2 attending physician I for use as the buria 0 Physician/Medical Subdural Hematoma Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 ☐ No ed by the a detached t 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 s autopsy death? 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6X Other (Specify) HOSPice 2 🗆 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No 09/09/2012 Investigation 11:00pm 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Nursing Facility, Manor Ca 28f. Location (Street and Number or Rural Route Number, MD City or Jown, State) 6530 Democracy Blvd. Bethesda, determined Manor Care Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 October 12, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 V 6001 Muncaster Mill Road, Rockville, Maryland 20850 Joseph, M.D. 32. Registre s Sig

DHMH 17 Rev 06-2011

Registrar